PUBLIC HEALTH NURSING

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A CALL FOR CITIZEN ENROLLMENT

From 1929 to 1933 public health nursing services were forced into the spot-light by the extraordinary importance of their position in safeguarding the nation's health. This condition has made many citizens alive to the value of community nursing. It has brought them into closer touch with surrounding health conditions. It has fostered an inquisitive spirit regarding health. It is the awakening of public consciousness.

Since 1912 when it was founded, the National Organization for Public Health Nursing has carried forward an active program designed to develop the intelligent interest of laymen in the public health nursing movement. During the last five years, particularly, this program has given hundreds of laymen a true appreciation of their responsibility as members of boards or committees of public health nursing agencies.

Nearly two thousand organizations engaged in this work depend on their boards for leadership, for funds, and for the proper interpretation of the organization's work to the community. With such a broad responsibility in its hands, it stands to reason that the quality of the board of directors and the effectiveness with which it discharges its obligations, frequently, if not always, determine the success of the nursing service itself. Undoubtedly there are local groups where effective work is being done by the nurses even though the board members have little or no interest in their community health problems, in the education of their staff, in the development of voluntary services, or even in attending meetings. Such agencies are very rare.

Staff nurses are only human. Almost always they respond to intelligent leadership. They have confidence in the decisions of a board which is intelligently informed on public health nursing and administration policies.

It is axiomatic that the community which has the best public health nursing is the community which is the most interested in its nursing service.

In order to keep awake this nation-wide citizen interest in public health nursing, the N.O.P.H.N. is carrying on, this month, an extensive enrollment effort among men and women actively concerned with community nursing. Pertinent facts regarding the citizen and the N.O.P.H.N. are being brought to their attention. One is that every layman should maintain a *national* point of view in judging her local service. It may be true that no two nursing agencies are exactly alike, but it is equally true that methods developed elsewhere may be adapted to fit the needs of a particular community. Unless board members keep themselves informed of progress throughout the country, they may soon find their own methods of administration out of date.

The N.O.P.H.N. Board and Committee Members Section has given the layman an opportunity not only to study the methods by which she may meet her local problems in community nursing, but has enabled her, also, to grasp the importance of public health nursing as a national activity—to understand the relation of the whole to its component parts.

A second point in favor of national participation of laymen is its effect on the staff nurse. Most public health nurses connected with enterprising local agencies are N.O.P.H.N. members. They belong not only because of the numerous direct services they receive,

but in order to maintain a national organization which continuously strives to improve the quality and technique of their work. The staff nurse rightly expects that the same support will be given the National by her board. She knows that such participation indirectly supports her also.

Any movement which is dependent for its existence on the understanding and appreciation of a major portion of the public, yet which is fostered and developed by an organization supported largely by the small professional group engaged in the practices of the movement, is in an unfortunate position. Yet the N.O.P.H.N., which has been greatly responsible for the growth of public health nursing during the last twenty years, is supported mainly by the dues of professional members, local organizations which call upon its staff for advice, and by the gifts of a few individuals.

Obviously, if it is to meet the increased demand for service which always accompanies greater appreciation of worth, it must widen the basis of its support. It must secure the support and active participation of men and women whose sense of civic responsibility has brought them into close contact with local health problems.

The membership of these individuals in the N.O.P.H.N. must be counted, in part, as their support of a national undertaking. But the fact that it has a financial aspect must not be allowed to detract from the fact that only through such membership can the layman maintain touch with the advancement of administrative methods in all parts of the country and yet, at the same time, continue to improve her understanding of her own local job. There is only one *national* organization in public health nursing and that is the N.O.P.H.N.

MAY DAY-CHILD HEALTH DAY

On May 1 will be celebrated the tenth anniversary of National Child Health Day. In the years since its initiation by the American Child Health Association in 1924, the observance of the day has undergone significant changes. Steadily from May Day to May Day communities have come to understand that teamwork for child health is for the best interests of children.

Of all the values of May Day-Child Health Day, perhaps the greatest is the opportunity it presents to enlist the active interest of groups which might otherwise not give the subject of child health any particular thought.

The spirit of coöperation, be it purely local or state-wide, has been fostered by the activities which have had May Day-Child Health Day as their inspiration. Communities working together for a single project, have received a taste of real coöperation, and have discovered its values as well as its difficulties. They have found that working together was time-saving, money-saving, and life-saving.

At this time, more than ever, when appropriations and budgets are being almost universally cut, individuals and groups should strive to come together for child-saving programs connected with the urgent needs of the hour.

The Conference of State and Provincial Health Authorities of North America, the body which last year assumed the future responsibility for the national conduct of Child Health Day, believes that adequate care for babies and for expectant and nursing mothers must be the foundation on which to build a nation of healthy children. They have therefore elected to continue the use this year of the slogan, *Mothers and Babies First*. The health officers are fighting to maintain the public health measures which they believe most necessary to protect infant and maternal health. They need popular support as never before.

More often, however, communities decide on their own local projects, which may cover babyhood, the preschool age, or the child at school, or all three. Wherever or whatever the project, National Child Health Day is becoming year by year more productive of practical results.

THE SURVEY OF PUBLIC HEALTH NURSING

The publication of the *Survey of Public Health Nursing in the United States: Administration and Practice*,* at this opportune time, will bring much interest to all those concerned with public health nursing. This survey conducted by the N.O.P.H.N. was made possible by a generous grant from the Commonwealth Fund to which the N.O.P.H.N. and all public health nurses are deeply indebted for support of the efforts of the nursing group to improve their service.

The methods of conducting public health nursing which fitted the community needs in the early days of our history have had to be adapted and readapted to rapidly changing conditions; the very conception of the words "public health nursing" and of the fundamental guiding principles have undergone constant revision as our horizon has widened and our field of usefulness has touched, overlapped or been absorbed by that of other organized groups of health and welfare workers.

It was with three specific aims in view that the survey was undertaken:

(*a*) To find out to what extent our present practice conforms to the present "generally accepted" standards and criteria, and to what extent deviations are healthy adaptations to local needs, or are due to ignorance or lack of attainment of standards.

(*b*) To find out whether these same standards are adequate and, if not, to seek ways in which they may be revised.

(*c*) To point the way toward new and more intensive studies of quality, results, and needs in public health nursing.

The survey was conducted by three well trained, broadly experienced public health nurses working under the advice and guidance of the N.O.P.H.N. Director and the Committee on Field Studies and Administrative Practice. The plan included studies of organization and administration practices, personnel qualifications, and nursing performance throughout all sections of the country and in all types of agencies (falling generally under the headings of private public health nursing associations, boards of health and boards of education). It was conducted through office conferences, home and school visits with staff workers. The analyses of work observed were carefully tabulated and rated by disinterested objective measurements. The whole project is wholesomely characterized by an objectivity in self-analysis which promises well for an equally constructive and impersonal approach to indicated measures for improvement.

To quote from the report: "Much that the study brought out was already known, and sporadic action is already being taken in regard to it. But never before has there been gathered together such conclusive and substantiating evidence" of the present accomplishments and needs in public health nursing.

The study must be read for full appreciation of its content, but all evidence points primarily and conclusively to the need for more and better preparation of the nurse for her special work in the field of public health, through every avenue possible,—in training school, student affiliations with public health nursing agencies, graduate courses in public health nursing, and continuous staff education and supervision of the nurse on the job, as well as self-education.

Since the study showed the public health nurse's performance in all fields of activity to be weakest in that very phase of her work which supposedly distinguishes public health nursing from other types of nursing—that of teacher and interpreter of health principles—the need for increased emphasis upon the instructive methods and opportunities is particularly urgent. Further experimental effort to study the application of educational principles and methods to the particular setting in which the public health nurse must do her teaching, in intimate home contact or informal group, may well be encouraged.

In all the extensive fields of public health nursing, whether administered by

*The Commonwealth Fund, 41 East 57th Street, New York, N. Y. $2.00.

boards of education, boards of health or private organizations, the attainment of our goal of maximum usefulness to the individual, family and the community seems to require more and improved machinery for close planning with other community agencies, and a testing of internal organization and administrative practices in each agency by those methods already found most successful and generally accepted as sound.

SOPHIE C. NELSON

OUR MEMORIAL COLUMN

It is becoming our custom in May of each year, since we are unable to include obituary notices in our news notes, to list those public health nurses who have died in service during the past year. We rely on our readers to send us word of those of their fellow workers who have passed from among us.

The victories of Right
Are born of strife.
There were no Day were there no Night,
Nor, without dying, Life.

—Morris.

Laura Baxter, October 20, 1933, in New Hampshire. Red Cross Public Health Nurse, Kittery, Maine.

Lydia Clara Blakely, June 23, 1933, Wichita, Kansas. One of the first school nurses in Wichita.

Marion Brown, October 25, 1933. Public health nurse for village of Liberty, Sullivan County, N. Y. Killed in an automobile accident en route to a teachers' conference.

Ellen B. Buckley, September 22, 1933, Hartford, Conn. First school nurse in Hartford. Died after a long illness.

Mary Carter, February 25, 1934, Salt Lake City, Utah. Hostess, United Air Lines, killed on duty with seven others in airplane tragedy.

Sue V. Confer, November 23, 1933, Philadelphia, Pa. Supervisor, Philadelphia Visiting Nurse Society, died suddenly following an accident.

Hattie E. Douglas, October 3, 1933, West Rutland, Vermont. Secretary, Vermont Board of Registration for Nurses and Community Nurse of West Rutland. Died suddenly of apoplexy.

Nell Dunavant, January 5, 1934, Joplin, Missouri. Metropolitan Life Insurance Company Nursing Service.

Katherine Keegan, June 26, 1933, Hudson, New York. Metropolitan Life Insurance Company Nursing Service.

Alma G. Leary, November 23, 1933, Astoria, Long Island, N. Y. Staff of Baby Health Station in Astoria. Died at her work.

Clymena Lysitt, October 7, 1933, Buffalo N. Y. Red Cross Public Health Nurse, Clara Barton Chapter, Dansville, N. Y.

Nannie Jacquelin Minor, Lewisburg, West Virginia, recently, following a long illness. Formerly State Supervising Nurse, Department of Health, Richmond, Va.

Carlee Muse, March 3, 1934, Paragould, Arkansas. Metropolitan Life Insurance Company Nursing Service.

Alice Seribner, October 11, 1933, Chesterton, Indiana. Stewardess, United Air Lines, killed in airplane crash.

Edith Shepherd, June 9, 1933. Tuberculosis Division, staff nurse of Detroit Department of Health, Detroit, Mich.

Marietta Burtis Squire, December 21, 1933, Orange, N. J., following a long illness. Miss Squire was formerly Welfare Director, Gimbel's Department Store, New York, N. Y.

Susan Desk Swarts (Mrs. Lester), August 21, 1933, Campton, California. County Health Nurse, Valencia County, California.

Jane M. Wiley, November 10, 1933, Portland, Oregon. Former county nurse and staff member of Bureau of Dental Hygiene, Extension Division, University of Iowa. Died following an automobile accident.

Valeria E. Wolfe, January 12, 1934, Lebanon, Pa. Industrial Nurse, Bethlehem Steel Corporation.

The Mental Welfare of Normal Infants*

Methods of Protection and Supervision

By ARNOLD GESELL, M.D.

PEDIATRICS, pediatric nursing, and public health nursing will from sheer necessity have to take increasing cognizance of the mental, *i. e.*, the psychological, factor of their common problems. Nearly every situation in medicine whether preventive or curative raises problems of mental health. We can not meet the almost universal challenge of these problems by setting up separate subdivisions of psychiatry or of mental hygiene to deal with them. The problems of modern medicine, public and private, cannot be solved through processes of professional subdivision. It therefore seems that pediatrics in one form or another is destined to take a controlling responsibility in the protection and supervision of the mental welfare of normal infants. It is significant that this type of work is evolving under medical auspices and medical safeguards.

Pediatrics holds a unique position in the whole scheme of medicine and of public health. Pediatrics is a specialty and yet it is not a specialty. Most of the specialties in medicine deal with some special functions or structures of the body—the eyes, the ears, nose and throat; the nervous system, etc, Pediatrics, however, is concerned with the young infant as a whole. It is, as Osler once said, "the specialty of general medicine."

It is very significant that modern pediatrics is first of all concerned with the basic problem of nutrition both in the sick and in the well child. In the beginning no hard and fast lines are drawn between the sick and the well, and the major duties of pediatrics, as a preventive branch of medicine, consists in the supervision and promotion of the child's development under all conditions.

RESULTS OF THE DEPRESSION

The close relation between mental and physical welfare has been emphasized by the recent depression which is bearing with heavy weight upon the whole population including even infants and children of preschool age. Malnutrition and illnesses both among the young and the old have unquestionably increased as shown by recent studies in Detroit, in New York, in the mill towns of Maryland, by the American Friends Service Committee in Pennsylvania, the Department of Public Health at Springfield, Ohio, the Children's Bureau of the Department of Labor, the Association for Improving the Condition of the Poor, and the East Harlem Nursing and Health Service. Even the old diseases of rickets and scurvy have shown an increase.

Closely associated and bound up with this reduction of physical stamina has been a reduction of mental stamina. The Children's Foundation of Michigan reports an increasing number of children who have come to the health centers because of nervousness, hypersensitivity, physical complaints with no organic basis, overmastering fears, lying, stealing, and other tendencies. Baffling behavior problems arise in erstwhile and potentially good children because of these circumstances. Even young children have become prey to anxiety. Unquestionably such psychological conditions have been tragically increased by the depression.

The point of view which needs to be stressed is that even the nutrition of the infant cannot be conceived narrowly in chemical or dietetic terms. It is surprising how rapidly and decisively the problems of nutrition become problems of psychology of the infant. Nutrition is dependent upon methods of care,

*A paper read before the annual meeting of the New York State Nurses' Organizations, Rochester, New York, October 18, 1933.

methods of ministration, and of management. The functional and psychological factors cannot be divorced from physical hygiene. And if we wish systematically to protect the mental welfare of the rising generation, we must begin with the new-born child and recognize the psychological aspects of development from the moment of birth.

These statements are a bit abstract because they express a point of view but I should like to make them concrete and quite tangible. We need not think of mental welfare in mystical terms only. In the field of public health we must attempt to reckon with mental welfare with the same realism that we approach problems of rickets and diphtheria, knowing full well that nervously and mentally sick adults of today occupy as many hospital beds as do those who suffer from all other illnesses put together.

A WORKING CONCEPT OF THE MIND

How can we make this approach concrete and tangible? We need a working concept of the mind which in essence is as substantial as our concept of the body. We cannot weigh the mind in a balance as the nurse weighs the infant when she assists in the supervision of his physical welfare. But the mind is none the less a structured organism. It develops with the same certainty, precision, and differentiation which the body manifests during the whole period of infancy and childhood. Mind as well as body grows. This growth is a process of organization which expresses itself in progressive patterns of behavior. Even though we can not handle these patterns of behavior, nor measure them with a tape or with the scales, we can observe them, appraise them, and follow their orderly growth.

We find, for example, that typically a twelve-weeks-old infant will regard a wooden cube which is placed before him on the table top; that a twenty-weeks-old infant will contact the cube. At twenty-four weeks he will grasp it in his palm and at forty weeks he may grasp it with his finger tips. At eighteen months he can build a tower of two or three cubes but ordinarily it takes him another eighteen months, *i. e.*, he must attain the age of three years, before he can combine these cubes into a simple bridge.

By the use of the moving picture we can note the infant's reactions to the two-cube situation. One cube is placed in his left hand by the examiner, a second cube is placed on the table top before him. His behavior reactions can be shown at normal speed, then at slowed speed, and then in dissected, stopped-motion pictures which will delineate the salient movements in the various reaction patterns. Then we can call upon the technology of the cinema and bring these two age levels into immediate juxtaposition. The selfsame infant is coincidently shown at twenty-four and at twenty weeks in comparable behavior situation. By this method of coincident projection the cinema resolves the past and future of the infant into a simultaneous present. The increments of mental growth will thus be made manifest.

AN INFANT AT 24 WEEKS

The infant has marks of individuality and these marks come into early prominence. He shows great physical nobility; he is, in a motor sense, dynamic; he takes great satisfaction in motor activity. He is also alert in the social sense; he has perception of the mood of others and is resourceful in adopting a corresponding mood; but he is not compliant and has in addition well defined negative reactions and a fairly robust temper. He shows self-dependence, likes to do things himself, insists on participation in motor activity in particular. In manipulation he displays interest in detail, delicacy of touch and a certain kind of mechanical aptitude. All of these characteristics are in large measure conditioned by his inherent capacities and inherent growth traits. His deportment is, of course, much influenced by the character of his home management, but it is very important that we emphasize his own original contribution to his behavior patterns.

These contributions have manifested themselves through the first year of life and will doubtless project themselves into the future.

THE CONCEPT OF GROWTH

Growth is a key concept. Certainly growth and guidance are two concepts that belong together and the growth concept must always be used generously as a corrective for over-zealous guidance concepts. It is so easy to forget that factors of growth underlie child behavior. Much that he learns he learns incidentally and without our instruction. In most child guidance situations we are prone to adopt rigorous ideas of right and wrong, of authority and obedience, of discipline and training, which make us blind to the almost axiomatic truth that the mind grows and that behavior can develop only in accordance with laws of growth which are as inescapable as the laws of gravity.

If optimal growth is the basic concept of child hygiene, it follows on the practical and administrative side that the protection of mental health depends upon organized forms of protection directed toward the conservation of the potentialities of growth. Translated into practical terms, the protection of the mental welfare of infant and child can be accomplished in four fields of social endeavor as follows: (1) Parental and preparental education; (2) Reconstruction of nursery and kindergarten; (3) Local clinics and guidance units; (4) Periodic developmental supervision. In all of these fields, and especially the last, the nursing profession has an active rôle to play.

PARENTAL AND PREPARENTAL EDUCATION

There are endless opportunities for the instruction and guidance of parents in the arts of infant care and of child training. Both the public school system and the public health nursing profession have responsibilities in this direction. To build for a more remote future, educational provisions must also be made for more adequate preparental training for young men and young women in their pre-adult years. We need adequate courses of instruction in human biology dealing candidly with the origin, physical growth, and mental growth of the human child. In this way we can bring into the curriculum a practical type of psychology concerned with the laws of human nature and with the development of the child mind. The professional training of the public health nurse likewise should embrace concrete courses in the developmental psychology of the child.

RECONSTRUCTION OF THE NURSERY AND KINDERGARTEN

We must reconstruct both the kindergarten and the nursery school in such a way that they will reach all the people and contact a wider range of the preschool years. Here again educational and nursing provisions may be brought into closer coördination.

LOCAL CLINICS AND GUIDANCE UNITS

Knowing the great prevalence of nervous and mental diseases, it is necessary from a preventive standpoint to make early discovery of abnormal developmental deviations. Child guidance centers should be at least as available as medical dispensaries. These clinical and guidance provisions should include a guidance type of nursery and guidance units in children's hospitals. Such units would make transient contact with a larger number of clients, the contacts being adjusted to the gravity of the guidance needs.

PERIODIC DEVELOPMENTAL SUPERVISION

Finally, and perhaps most fundamentally from the standpoint of public health nurses, is the concept of health supervision. From the community point of view this concept is most auspiciously and tangibly represented by the infant welfare station, the well baby conference, and the child health center. Through private medical practice, as well as through public health provisions, every progressive community now provides for periodic supervision of the child's physical growth. Favored sections of the community throughout the land are making increasing demands for the widening of this supervision to

include psychological development. Whatever organization medical service will assume in the next twenty years, it may be safely predicted that there will be provision for periodic developmental examinations which will include the mental hygiene of the child.

In an incidental way much work of this kind has been constantly done by the visiting nurse and by the consultation center and by physicians in private practice. But what is now being incidentally done should be done deliberately and systematically. There are minimum norms and standards of mental growth and of mental health which can be checked by periodic examinations. In a sense the psychological hygiene of a large mass of our young children is at the same low level as their nutritional hygiene was in 1892 when Dr. Budin established in Paris the first infant welfare center.

We now know that in these '90's sausage and dill pickles still figured prominently in the diet of even the very young. Their equivalent in the psychological field is today represented by misguided forms of harshness expressed in scolding, sarcasm, shouting, cuffing, beating, and similar inconsiderate methods of child management. Here is a very simple and concrete field of mental hygiene which lies open to every nurse who comes into contact with parents and their children.

In summary, then, we can envisage a more or less complete system of mental hygiene protection which is already in the making and which includes these four distinguishable methods of approach: parental and preparental education, reconstruction of nursery and kindergarten, local clinics and guidance units, and periodic developmental supervision. The methods of approach are distinguishable, but in actual operation they interact and function together both under private and public auspices. All of them concern the normal as well as the problem child. Nursing education, public health nurses, home nurses, all have contributions to make to the further development of the safeguards which have already taken shape. These safeguards must be strengthened, for experience of the past has taught us with no uncertainty how formidable is the weight of mental disability which may descend upon the future.

NEW HOME—EAST HARLEM NURSING AND HEALTH SERVICE

The friends of the East Harlem Nursing and Health Service will be glad to learn of a "New Deal" that has resulted in a gift to the organization of a modern, fireproof, three-story building located at 454 East 122d Street at the corner of Pleasant Avenue, one block east of First Avenue, New York City.

The building was erected in 1929 by the Kips Bay Day Nursery Association. When this Association decided to give up the maintenance of the Nursery, it was anxious to have the building used for work with mothers and young children. While the supporters of the Nursery closed their work with the greatest regret, they felt assured that the traditions of service to which the nursery had been dedicated would be carried out by the East Harlem Nursing and Health Service. An auxiliary committee has been formed by the Kips Bay group which will thereby continue its interest in, what is for them, a new venture.

An Index of Nutritional Status *

By GEORGE T. PALMER, Dr.P.H., and MAYHEW DERRYBERRY, Ph.D.

THE prevalence of malnutrition is a much discussed subject these days. There are many conflicting reports. Some of these state that there have been huge increases in the number of malnourished children. Others claim that the increases have been very small, while still others state that there is no real evidence on the subject.

But why do we have such conflicting reports? The reason lies partly in the basis used for determining whether or not a child is malnourished. Most of the reports are based on either the casual rapid inspections by doctors who are seeing the child for the first time or else on the number of children who are below weight for height and age. Neither of these are good indices to use in determining the prevalence of poor nutritional status.

WHAT ARE STANDARDS OF MALNOURISHMENT?

A child called malnourished by one physician will frequently be called well-nourished by another. This is not so serious for the individual child in the care of the family physician, for regardless of whether or not his physician calls him malnourished, the child will receive the care that is thought necessary. But when it comes to determining the number of children that are malnourished, that is another matter.

We actually found in one instance that the doctor who was very strict in observing signs of malnutrition selected fourteen out of a hundred as malnourished. Another doctor who was not so strict selected only two out of the same hundred as malnourished. Both may be right according to their own understanding, but changes in the prevalence of malnutrition cannot be settled using as a basis such variable standards. If doctors differ as much as that on the same group of children, how can we compare groups from time to time when the examinations are made by different doctors? Will our comparisons mean differences in the prevalence of malnutrition or will they mean the difference between doctors' opinions?

These facts are not really a criticism of the ability of doctors to diagnose and treat malnutrition. When they have an opportunity to follow a child over a long period of time, they know whether that child is properly nourished or not. But when we ask a doctor to see a child for a maximum of three to five minutes and in that casual inspection determine whether he is malnourished or not, we are setting an impossible task for him. Therefore these wide differences in opinion are to be expected.

Now let us consider the other standard of malnutrition on which many of the reports are based, namely, the height-weight-age standard. We are all familiar with it. For years schools have been weighing and measuring children and then reporting the children underweight for their height. Supposedly there was some scientific background behind such a procedure. But when we investigate more thoroughly, we find that it lacks scientific accuracy.

UNDERWEIGHT NOT A MEASURE

Beginning in 1926 the American Child Health Association made a careful research on the question. They measured children in cities scattered all over the country. The gist of what they found is this. The weight of a child of school age is determined very largely by the size and shape of his skeletal framework. Width of hips and depth of chest are important in determining weight; even more important than height. For example: two tumblers of the same height will not necessarily hold the same amount of water. The amount held by each depends on the diameter of the

*Presented over Station WNYC, January 30, 1934.

respective tumbler. The wider tumbler will hold more water and thus weigh more than the other tumbler. For the same reason children of the same height and the same age will not conform to a standard weight. Even though of the same height, the child with broad hips and deep chest will weigh more than the child with a less bulky frame. You can't call a child malnourished just because he has narrow hips. The size and shape of his build depends much more upon the build of his parents and his grandparents than it does upon his nutritional status.

Width of the framework has more effect on weight than has height. What has been found therefore is that children who are underweight for height are mostly those who have narrow and shallow skeletal frames. Those who are not underweight for height are mostly those with wide and deeper skeletal frames.

Therefore, reports on the proportion of children who are a certain per cent underweight are not useful as indices of the prevalence of malnutrition. Underweight is too much affected by skeletal build.

The research in which the Association engaged not only showed the reasons why underweight was not a good measure of nutritional status, but it also showed that malnutrition in general relates more to the amount of flesh on the skeletal framework than the size and shape of the framework itself. Of course there are rare instances where even the size of the frame will be affected by an extreme lack of certain essential foods in the diet. This has been shown by animal experiments. But among the general run of children in school, such extreme deficiencies seldom occur.

The amount of muscle and soft tissue is a very good index for measuring the state of nutrition. But these amounts must be considered in relation to the dimensions of the bony framework. Height is wholly inadequate. It is also necessary to measure the width of hips, the width and depth of chest, the girth of the arm and the thickness of soft tissue over the muscle of the arm. These things are necessary for accurately measuring changes in large groups of children.

THREE MEASUREMENTS NECESSARY

For practical purposes, however, the American Child Health Association has worked out a simpler, though fairly accurate procedure. This requires three measurements—arm girth, chest depth, and hip width. By this means it is possible for schools to pick out children between the ages of seven and twelve whose nutritional condition is poor. This index—called the ACH Index (Arm, Chest, Hip Index)—also serves the purpose of a standard measure by which groups of children can be compared and by which children in one place can be compared with those in another. The index is also useful to reflect changes from year to year.*

This index is designed to select children who should be referred to the physician for examination and advice. It is an *aid* to the physician and not by any means a substitute *for* the physician. While this index is useful for measuring groups and for selecting children for further examination, the final diagnosis and treatment of the child is of course the job of the doctor.

*Details concerning the index may be obtained from the American Child Health Association, 50 West Fiftieth Street, New York City.

Courtesy of Pro Juventute
Drawn by Hedwig Spörri-Dolder

A Baby Tent at the Fair

By CLARA L. CRAINE, R.N.

THE Davenport (Iowa) Visiting Nurse Association has had charge of the baby tent at the Mississippi Valley Fair, which represents a rather large territory of both Iowa and Illinois, since 1920, the first year the fair was held.

In planning the public health work for the fair we did not plan to take care of babies in a tent but to offer a definite public health educational program. Talks with demonstrations were scheduled for certain hours during the day. Posters and announcements were used to secure an audience. However, we found the majority of people who came to the fair came to see the exhibits—not to be educated. As the first day passed, we were distressed to see very young babies carried around in the heat and dirt, sometimes asleep, their heads hanging over mother's arm with the sun glaring in their faces. The second day was a repetition of the first, and a new program began to materialize out of necessity, for it did seem a time when public health nurses could demonstrate the care of babies under difficult situations. Thus, the baby tent was established, not, however, without considerable pressure being made on the Fair board to build a suitable building for the babies as soon as possible as they had for other necessary departments of the fair. To date, we still have only a tent!

We have had numerous requests to put on a competitive health program but have refused to do so without suitable quarters. Our tent has been carefully considered by the Fair board, and really is as good as the one used for automobiles. It is waterproof, of dark material which makes the sun less glaring. It is well placed; a good floor covers the entire space and it is well lighted. Two women who work at the fair sleep in the tent at night, cleaning the floor each morning for this privilege. The place is kept as spotlessly clean as possible, which, of course, adds to its attractiveness, and many are the favorable comments made by passersby.

We are ready to take in babies at 8:30 A.M. and we close promptly at 5 P.M. Most parents with little children are ready to leave the fair by that time, and it is surely a long enough day for a baby!

EQUIPMENT

The furnishings are four cots with protected mattresses covered with sheets. There are two long tables in the center of the tent, covered with sheets, to hold the six clothes baskets for the tiny babies. The youngest one we have cared for was two weeks old; they are usually at least three to five weeks old. These baskets are covered with sheets, the basket being put in the center of the sheet and side and ends drawn tightly and smoothly into place. A pillow with a newspaper pad slipped inside the pillow case completes the bed. These can be quickly and easily changed when necessary. Mosquito netting is spread over each basket.

Two babies' beds are used for older children. We do not take care of the run-about child; the Parent-Teacher Association has a place for them. Two baby cabs are used for babies who are awake and fretful. We have a small table covered with oilcloth for basin, pitcher, and soap dish, a scrap basket for waste, a hamper for soiled clothing and one for clean supplies, since everything must be kept under cover; two rocking chairs, benches around two sides of the tent, and a table with health literature complete the tent furnishings. The two tent poles are utilized for various needs, for instance: to hang fly swatters where one can reach them in a rush; a cotton pad with extra safety pins for many babies who come in with a triangular diaper and go out with it

folded square. Sometimes, diapers are forgotten so it is wise to keep a supply on hand.

ROUTINE OF CARE

A book is kept in which the babies are registered with their parents' names and addresses and their feeding time. If a bottle baby, the milk is kept on ice in the Woman's Club department across the way from the baby tent. If breast fed, the mother is instructed to appear promptly for the feeding. At this time we have an opportunity to talk with the mother on the care of the child, also to tuck in a little needed information on prenatal care, if the future calls for it! It is decidedly encouraging to meet a mother some six or eight years after our first contact and have her tell us how much she has been benefited by something she was told at our baby tent at the fair.

When the baby is registered at the baby tent, the mother is given a check number corresponding with the number in the registry, a corresponding number is pinned on the baby and on the package of necessary articles brought by the mother. This makes it quite easy to keep each child's things together.

GETTING ORGANIZED

Fair committees are appointed by both the Visiting Nurse Board and its Junior Auxiliary. These committees work very efficiently, both in helping plan equipment for projects and in giving service at the time of the fair—two from each group serving morning and afternoon. There are a supervisor and staff nurse always in attendance, and any of the other nurses who finish their afternoon work early enough, come out to help. There is no remuneration for the nursing staff, except admission to the grounds, meals and tickets to various entertainments.

OTHER PROJECTS

We have other interesting projects at the fair, such as supervision of the emergency hospital, a competitive booth illustrating care of the preschool child, oral hygiene booth, and a booth demonstrating good and bad living conditions.

All in all, good work is being done. Fewer and fewer babies are being toted to the fair and this, we believe, is due to the fact that we have carefully and patiently talked with the mothers about what could happen to a little child taken to spend a day at the fair. One of our visible demonstrations is a rope stretched around outside the tent to prevent the crowds of people from coming inside to "see the dear little babies." The rope serves, not only as a protection to the baby, but demonstrates to the mother the need of keeping the baby away from the crowd.

We also tell them of the mother who came with her baby and the nurse observed some suspicious looking pustules on her hands. She was placed in a corner, the doctor from the hospital called, and the condition diagnosed as small pox. Also, of the wee baby with a red rash who proved to have measles.

It is probably needless to add that we absolutely do not approve of a baby tent at a fair, but it is much better than having babies carried around in the heat and dirt. If babies must come to a fair, there is certainly no excuse for not getting over a public health message.

A Forward Step in Nursery Care

By LUNA E. KENNEY

CONSIDERABLE interest in foster day care as a new development in day nurseries has been manifested by those associated with health work. Therefore, in the short article which follows, perhaps more emphasis is placed upon the health aspects of this project than would normally be true if space permitted a fuller discussion of the plan in all its aspects.

This plan, which is not so revolutionary as some feel, provides daytime care in foster homes for children of working mothers. That it is an old and preferred method of child care was demonstrated by a survey made in Philadelphia by Mrs. Berthold Strauss in 1926, in which it was revealed that most of the children of working mothers were being cared for by relatives or neighbors, even in the districts where nursery service was available. As a result of this survey, Mrs. Strauss recommended that the mothers be offered the use of carefully selected and well supervised foster homes instead of the institutional service which had previously been considered the only possible plan for day nurseries. In December, 1927, the First Day Nursery (the oldest existing day nursery in the United States) began the placement of children in foster homes for day care, instituting a service which has since been adopted by three other Philadelphia nurseries, and is being tried out in various other cities.

ADVANTAGES OF HOME CARE

The advantages of this plan over the centralized day nursery seem to us many and valid. The child in his environment—not the child alone—is the unit of nursery work under this system, which places more emphasis upon the family, and aims directly at treatment of social causes rather than symptoms. If a family needs nursery care, it is usually because of some deviation from the accepted pattern of family life. Merely giving nursery care to the children does nothing to recreate home life unless a careful program of case work, which is the basis of, and can never be incidental to, foster day care, is carried out. The maintenance of family life with its center in the home instead of divided between the home and the day nursery, is to us very important. It is a more normal, therefore more acceptable, plan to both children and adults.

Again, under our present plan, we give service to a wide territory instead of the very limited one which is usual to the nursery with a central plant. This is especially helpful in territories where the need for nursery care is scattered. It would also be most useful in testing the need for nursery service in any given community before the erection and equipment of a nursery building.

One outstanding advantage of non-institutional nursery care is that there need be no age limits. The normal family has children of varying ages, therefore the normal foster home might care for either babies or pre-adolescents equally well. The consideration of age limits reminds us at once of the usual limitations as to color, creed, or nationality. We see that the conflicts arising in groups because of these differences are automatically eliminated by placing colored children in colored foster homes, orthodox Jewish children with orthodox Jews, etc., etc. Also, the child of professional parents may be placed in a home of corresponding calibre, whereas the child of the lower social group is placed in a foster home which is in all ways sound, but which has enough similarities to his own that he may adapt the pattern of life presented to him in the foster home to his own daily experience.

Further advantages of this plan may be found in its extreme flexibility. It is just as easily fitted to the unusual situations presented by problems of the de-

pression as to the more typical nursery cases. If employment increases, further children can be cared for without the addition of new buildings and equipment, and if the contrary is true, nursery service can be decreased without considering the bugbear of every institution—*i. e.*, exorbitant overhead costs. If the family is large (and we have demonstrated that it is usually wasteful socially and financially to keep more than two children of one family in any place other than the home), we can work out some plan other than placement in institution or foster home. The mother may be subsidized at home, a "traveling foster mother" may be sent into the home, or any one of many plans put into operation. If the mother of a small child works at odd hours, as many waitresses, cleaners, telephone operators, and others do, the mother may secure a room in an approved foster home, so the child may pursue a normal routine without being taken from his home for nursery care. If illness overtakes the child, the foster mother often cares for the child in his own home so the mother may not have to stay away from work. *In every case a plan may be made to fit the peculiar need of the client.* We submit that this is the primary obligation of every social agency.

ECONOMY OF THE PLAN

We dare not, in this day, consider any new (or old) plan without taking into account its financial advantages or disadvantages. We have found through careful study that this is an economical method of giving nursery care. One day nursery found in comparing its own costs of institutional care and foster day care, that the cost of 6,808 days' care in the institution was $9,835, whereas in the first year under the new system, the total cost was $8,913, for which 9,376 days' care was given, and case work service to other children not actually in the nursery cost $1,782 of this total. Surely we cannot afford to ignore the financial implications, even though we should never consider the adoption of the plan purely on the basis of financial economy. Space does not permit a detailed discussion of costs, though more comprehensive statistics are available, and others, which we believe will be of interest, are being compiled.

ATTENTION TO HEALTH

We cannot close the discussion of the good points of this work without giving attention to the health of the children. That we can do satisfactory health work under the decentralized plan was indicated when our nursery without any unusual campaign for health, won the first prize in the 1933 May Day health contest held by the Philadelphia Association of Day Nurseries. A part of the credit for this is due to the fact that our children are not exposed to contagion or infection in the nursery group. We were particularly impressed by this feature during the epidemic of infantile paralysis in this city in 1932. At that time, our program was in no way disrupted, and we were not faced with the problem of arranging for care for the nursery children who were barred from groups by action of the Board of Health.

It is not fair, however, to say that our successful health work is due to the factors above mentioned without remembering that health is stressed in our contact with the families from the moment of our first contact with the children. The usual admission requirements of vaccination, Schick test, and toxin-antitoxin, negative, smears, etc., start the health work off well. Regular physical examinations follow. Added to that, consistent education of the parents as to the child's need for proper diet, plenty of rest, a peaceful home life, and the necessity for carrying out needed physical corrections, and you have the framework upon which our health program is built. And surely, no health program is sound that does not include parent education of the type mentioned. It is much simpler to give Johnny his daily ration of cod liver oil in the nursery than to make sure that Johnny's mother understands why he needs it, and therefore administers it at home,

but the results by the latter method are, we maintain, more lasting and more sound.

Both the foster mother and the nursery worker combine their efforts to teach the mother the fundamentals of personal hygiene and proper diet. When these standards have been consistently presented to the mother as something possible for her to attain (for is not the foster mother, who is in approximately her own economic group, able to attain them in her simple home?)—then, and only then, may we feel that we have done health work of maximum efficiency. We have found that the health of not only the nursery child but of the entire family group is much better under foster day care than under our former institutional system. The implications of this statement merit consideration and discussion.

ARE THERE ANY DISADVANTAGES?

The preceding discussion brings us naturally to the question, "What are the disadvantages of foster day care?" We state quite honestly that we have not discovered any insurmountable difficulties in the working out of foster day care. However, we may consider briefly the objections which are most often offered to us as a reason for rejection of the plan.

The first objection is usually that this plan does not provide for a nursery school. This is true. Neither is it opposed to the nursery school. In fact, one foster day nursery has given over its institution to the use of a nursery school. We believe that the nursery is essentially a relief agency, not an educational project. If we choose to make a demonstration of any specific educational project, it should be so known, and so financed. Inasmuch as the White House Conference Committee definitely classified day nursery service as "relief to dependent families," it is appropriate to inquire whether the relief agency is the one to demonstrate an educational project. We should also remember that it is fallacious to supply expensive education to the preschool child unless we carry on simultaneously a case work program directed at the cause of the child's maladjustment.

Another suggested disadvantage of foster day care is that it does not give opportunity for group contacts which are so essential to every child. Here we feel that the kindergarten, the nursery school, and other schools and clubs may be used to complement foster care if it seems best. It is not necessarily true that formal group life is more beneficial than informal groups such as found in the normal family and neighborhood contacts of children in their own homes or in foster homes. The child's individual need to learn how to play with other children, to help himself, etc., can be and is met by a capable foster mother in most cases. If the case is so acute as to need special attention, we do not hesitate to utilize whatever educational institutions are at hand.

A third registered objection is that "foster homes do not have the play space and equipment that is found in the day nursery." Here it is well to remember that two children do not need the play space that forty do, nor do they need the elaborate sanitary equipment which is occasioned by the existence of the group. When the group is dispersed, the need is found to be identical with the need of children in private homes. Sound foster home-finding requires the selection of homes that meet the recreational and sanitary needs of the children to be placed, so we again consider the objection invalid.

Another frequent objection is that working neighborhoods cannot offer the proper type of foster home. To this we reply that if a family is of poor type solely because of a modest income, we cannot hope to find proper foster homes in such districts. However, experience has shown clearly to us that every type of neighborhood—and when I say this, I mean factory, rooming house, residential, business and just plain slum sections—will yield unexpectedly sound and satisfactory foster homes *provided the worker is earnest and diligent in her search for them.*

We have never yet been unable to find a good foster home for a child, and

our territory includes all the types of neighborhoods mentioned. We admit readily that certain neighborhoods make foster home finding more difficult, but we do not concede the impossibility of finding homes for practically every type of child. Whenever the impossibility is thoroughly demonstrated by a trained and experienced home finder, we shall gladly alter our opinion. Until then, we must accept our own experience of the past six years as being the most authentic basis for judgment.

I am aware that this short article has left many points untouched, and others have been treated inadequately. I regret the necessity of this, and assure my readers that those who wish further information regarding our work will receive our prompt and thoughtful attention to their inquiries, whether made in person or by mail.*

*Information may be secured by addressing the writer at the First and Sunnyside Day Nursery, 3627 Warren Street, Philadelphia, Pa.

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Florence Nightingale

May 12, 1820—August 13, 1910

Florence Nightingale's recipe for handling committees, quoted from Reginald Berkeley's play, "The Lady with a Lamp" (Act II, Scene II):

Palmerston: "But you don't quarrel with the committees, I hope?"
Florence: "No, I manage them. Mix in a committee room with a seasoning of statistics. Add expert opinion to taste. Stir in a little common sense. Simmer for a few hours—and leave it to set in a cool place!"

"Give them plenty to do and great responsibility—two effectual means of steadying people."

"Again, people who are in charge often seem to have a pride in feeling that they will be 'missed,' that no one can understand or carry on their arrangements but themselves. It seems to me that the pride is rather in carrying on a system so that anybody can understand and carry on—so that, in case of absence or illness, one can deliver everything up to others and know that all will go on as usual, and one shall never be missed."

Florence Nightingale's *Notes on Nursing.*

Chronic Rheumatism*

By HERBERT L. LOMBARD, M.D., M.P.H.

PRIOR to the first care given by a human mother, prior to the advent of man, back some fifteen million years ago in the period of history known as the Mesozoic Age, chronic rheumatism was flourishing. The fossils of this period demonstrate that animals had the disease. Later fossils show its presence in men of the Old Stone Age. Sir Frederick Eve found evidence of this disease in skeletons of the ancient Egyptians. A medical papyrus from Thebes of about 1550 B.C. actually describes arthritis deformans. Inasmuch as the remains of men of the Old Stone Age are not numerous and inasmuch as in the specimens available lesions of rheumatism appear, the belief that the disease was quite prevalent in this early period seems tenable. Whether it has increased, decreased, or remained the same over the ages cannot be ascertained. In fact, we cannot say with any degree of precision what changes have occurred in its incidence in the past hundred years. Our information on this point is largely obtained from studies of mortality records. While for many diseases we are able to speak with some degree of precision on their changing epidemiology, we cannot study chronic rheumatism from death records for the disease rarely kills. Its many sufferers are classified in the death records as victims of other diseases.

MORE PEOPLE HAVE RHEUMATISM

It is believed that a greater number have rheumatism today than in previous generations. This assumption is based on the increasing age of the population. Two generations ago the average age of all men, women, and children at time of death was thirty-one years. At the present time it is fifty-four. With more individuals arriving at the age where rheumatism is the most prevalent, the assumption of increasing number of cases seems warranted.

The term "rheumatism" as used by the laity is indefinite and may designate various conditions. Although these include neuritis, myositis, and various aches and pains, the majority of the cases will fall properly under the classification of arthritis. The term "arthritis" is much older than that of rheumatism. It dates back at least to 1550 B.C., while rheumatism was first introduced some three thousand years later. Rheumatism was derived from the word "rheum," which was one of the four humors of the body. Arthritis has a Greek derivation, "arthron," meaning joint.

A SURVEY OF THE SITUATION

The Massachusetts Department of Public Health has studied the situation using data derived from house-to-house surveys. Records have been obtained from 75,000 individuals in the State, so scattered geographically as to be a fair sample of Massachusetts and probably of the northeastern part of the United States. The rheumatism figures furnished are based on Massachusetts studies and wherever Connecticut figures are given the assumption is made that citizens of that state resemble those of the neighboring state, Massachusetts.

INCREASES WITH AGE

Approximately three-quarters of the rheumatism cases found in the survey had arthritis and the remaining quarter was divided among other classifications. While the diagnosis furnished the surveyors was that given by the individual questioned, in about three-quarters of the cases this had been confirmed medically. Of the total population over forty, one person in every ten had rheumatism, and between the ages of forty

*Presented at the annual meeting of the Connecticut State Nurses' Association, Hartford, Conn., February 8, 1934.

to eighty, eighty-three per cent of all cases occurred. Up to the age of eighty the disease increased with age and one out of every four between seventy to eighty was afflicted.

Connecticut has in the neighborhood of fifty thousand individuals with this disease. This is equivalent to one-third of the population of the city of Hartford. A disease with a ten per cent morbidity over the age of forty warrants attention, but the fact that few die as a result of it tends to make it lightly thought of by the masses. Rheumatism cripples, though it rarely kills. If death were the end result, everybody would fear it. It is twelve times as prevalent as cancer, but only one-fortieth as fatal. Disability is marked. In Connecticut today there are probably two thousand individuals completely disabled with this disease—individuals confined either to the bed or to a chair and needing the constant care of some other person. There are others who are confined to the house only part of the time with the disease, and still others who are obliged to change their type of work because of partial disability. The amount of time lost by wage earners on account of disability from this disease is so great that if figured on a $4.00 working day it would amount, in Connecticut, to approximately three million dollars yearly. Money spent for hospital, medical, and nursing care is not included in this figure, nor is the money used to hire help when the wife of the house is afflicted. No reckoning is made of the time lost by non-wage earners. The suffering of the individual, the worry and additional cares of the family are not included. These cannot be translated into dollars and cents, but their volume is so great that the humanitarian aspects are of even more significance than the economic.

FACTORS IN THE DISEASE

The survey showed that rheumatism was more prevalent in rural communities than in urban. Females were more frequently attacked with the disease than males. Individuals with poor economic status had nearly twice as much rheumatism as the well-to-do. Poor hygiene was found to be intimately connected with the disease. Overweight, infrequent or non-use of the protective foods, infected tonsils, poor teeth, chronic indigestion, frequent use of laxatives, nervous temperament, lack of exercise and long-continued acute illnesses were associated with the disease. Those living in damp houses had more rheumatism than others. Of the variables showing association with rheumatism it is impossible to say whether all of them are of equal importance, as the presence of one variable may cause that of a second. For example, a person with a diet largely carbohydrate might become overweight and the rheumatism may be due either to the lack of protective foods in the diet, or the overweight, or perhaps both. It is probable that the relationship between rheumatism and poverty is due to the environmental influences. The poor are unable to have as good a diet as the wealthy. They cannot afford good dentistry. They are less apt to call physicians for the various foci of infection.

PREDISPOSING CAUSES

The findings of the Massachusetts surveys are in close accord with the opinions of various writers on the predisposing causes of rheumatism and it would appear that fatigue, endocrine deficiency, malnutrition, foci of infection, poor excretory functions, faulty digestive systems, and heredity were the important causative agents for this disease. The prevention of this disease lies largely in hygiene. We are not yet in a position where we can choose our grandparents but we are able to go to bed when we have slight infections, to care for our teeth, our tonsils, our digestive tract, to eat the proper foods, to rest, to exercise, to avoid constipation and overweight. It may be impossible for many of us to live in climates unfavorable to the disease but we can endeavor to choose houses with as little dampness as possible.

WHOSE RESPONSIBILITY?

Public health officials should attempt to disseminate information on the rela-

tionship of hygiene and the prevention of rheumatism. This certainly is a function of governmental agencies, questioned by none. Another function, which is no less clear, is that of continued studies on the disease. The epidemiology of rheumatism is by no means settled, and while the information regarding its care and treatment in Massachusetts is of value, further studies along these and other lines should be made elsewhere. Should public health go beyond this point? Should it reach out into the care and treatment of this disease?

Individuals are not receiving sufficient medical treatment. The survey indicated that one-half of the well-to-do individuals with rheumatism were not under the care of physicians and about four-fifths of the poor. Many felt that the medical profession offered them no help and a number said they had lost their faith in doctors. They read in the various lay magazines, and perhaps occasionally in the professional, of what is being done to alleviate this disease in different parts of the world and they wonder why their doctor is not equipped to render similar service. They go from physician to physician asking for help, and finally deciding there is no help, resort to self-medication and the corner drug store.

NOT ENOUGH KNOWN—NOT ENOUGH FACILITIES

Behind this criticism lies the fact that in the past the treatment of arthritis has been most unsatisfactory, the chief reason being that this disease touches many different fields of medicine. To properly handle the disease requires investigation of many parts of the body. Even the symptoms of the disease vary so that mistaken diagnoses sometimes occur. Pemberton cites cases which were diagnosed neurasthenia by both neurologists and internists but when treated for rheumatism a cure was effected. The treatment of the disease often requires measures that receive little attention in the medical schools. Physiotherapy, manipulation, and massage are not well understood by the average practitioner. The disease has no single form of treatment but each patient must be studied both from a diagnostic point of view and of treatment in order to obtain the best results. With difficulty in obtaining a diagnosis of the causal factors and with methods of therapy not readily at the hand of the average practitioner, failure of the profession in many cases to improve the condition of the patients seems the logical sequence.

HOPEFUL RESULTS UNDER PROPER TREATMENT

On the other hand, the reports from physicians in clinics where this disease is being specially treated show cure or improvement in a large percentage of individuals. Pemberton summarizes his book on arthritis by stating that seventy-seven per cent of his army cases completely recovered and twenty-four per cent of his civilian cases, and in the army only four per cent were unimproved and in the civilian group only nine per cent. Hall reports from one of the Boston hospitals that good results were obtained in sixty-six per cent of the cases and partial results in twenty-nine per cent, making a total of ninety-five per cent helped. With definite improvement in three-quarters of all cases of rheumatism possible, and with two-thirds of individuals having rheumatism receiving no medical treatment, it is evident that something must be done.

Certain physicians in Massachusetts dealing largely with this type of case feel that the answer is a rheumatism hospital under governmental control. They cite the spas in European countries and feel that this country should be as able to treat rheumatism as England, Germany, Austria, Hungary, France, Belgium, Holland, and Sweden. In such an institution the various specialized forms of treatment could be given and the general practitioner could send his patients for a complete diagnosis to determine what disorders of the body have caused the rheumatism. The Massachusetts Department of Public Health introduced a bill for such a hospital some three years ago, but it failed

to pass. One physician believes there should be a central hospital with field units to care for many of the patients in their homes. That there is a need for more hospital service for rheumatism is admitted. How this should be attained is undetermined. Should it be done by governmental agencies or private philanthropy? If by government, should it be public health?

WHAT IS THE RESPONSIBILITY OF THE NURSING AGENCY?

Nursing organizations are greatly disturbed over the sphere of their duty in this disease. They encounter individuals with rheumatism in almost every home that they visit. How much time should they give to these sufferers? The head of a large organization told me that she could keep her whole organization busy simply by caring for the arthritic cases, but, she added, "I have only so much money and beyond giving them a moderate amount of care I can do nothing. I must take care of the pregnant women, the babies, and the acute sick, yet I know I am neglecting a great many individuals needing the type of service I have to give."

Similar problems face nearly all nursing organizations and it is one that needs to be thought through. Rheumatism is a disease that is very prevalent. It attacks all classes of society, but the poor to a greater extent than the well-to-do. Only a small percentage of the sufferers are receiving adequate medical and nursing service. Hospitals cannot fill their beds with chronic sufferers. Specialists in the disease are obtaining cure or great improvement in about three-quarters of the cases. The disease is undoubtedly associated with poor hygiene and this knowledge should be disseminated by health authorities. Further study of the epidemiology is necessary. A solution to the problem of how adequate care and treatment can be given to sufferers from this disease must be found. A disease that is totally crippling one person out of every two hundred in the population of this country should be attacked in a vigorous manner. The *modus operandi* of such a program of control lies in the hands of the citizens as a whole—physicians, nurses, health officials, and laity. Concerted thought, followed by action, is the solution.

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IMPERATIVE

"Mother, may I go walking,
With Nancy and Louise?"
"I'm hurrying through a letter,
Don't talk to me now, PLEASE."

"Mother, my shoe-string's busted,
Have you another one?"
"I'll look in just a minute,
I'm busy, now, my son."

"Mother, the motor's waiting.
Dad says it's time to go."
"Tell him I'm coming right away . . .
I must knot off this row . . ."

"Children, get washed, it's tea-time.
You're dirty as can be!"
"Mother, we're almost through the game
"Children, start INSTANTLY."

—Julia Weld Huntington.
Hospital Social Service, Nov., 1933.

Nursing in High Schools -- A Study

By MARY ELLA CHAYER, R.N.

THE Office of Education, under the leadership of Dr. Leonard Koos, has recently completed a National Survey of Secondary Education, one section of which was devoted to Health Work and Physical Education. Monograph No. 28,* transmitted in March 1933 "represents an effort to secure information concerning the progress of health and physical education in the schools. It was prepared by P. Ray Brammell of the special survey staff who used both the inquiry form method and personal visiting in the investigation." . . . This investigation aims to summarize the practices among a large number of secondary schools cited to the survey as having promising innovations in the field of health work. Consequently this is not a study of the status of health work among secondary schools in general. The major purpose of the study is to show the direction in which the schools most active in this field are moving.

Eight hundred fifty-one schools were thus selected to represent all sections of the country, and all types and sizes of schools. Replies were received from 460 schools. In June of 1932 the writer, through the courtesy of Dr. Koos and Dr. Brammell, was given access to the original data and to the tally sheets compiled by Dr. Brammell in order to determine what items of information were pertinent to school nursing. The examination of these data revealed the fact that every item was of significance to school nurses. But since the study was directed toward the entire school health program and not toward analysis of any one professional group, the writer determined that a further study of the place of the nurse in the high school program was highly desirable. Of the 460 schools studied through the national survey, 317 reported access to nursing service, either through their own organization or through local, county or state departments of health or other private organizations.

In January, 1933, the writer sent questionnaires to these 317 schools for the purpose of securing the following information concerning the nurse in high schools:

1. By whom employed and directed
2. Number of hours per week in school work
3. Nurse-pupil load
4. Health facilities the most closely related to the work of the school nurse
5. Health personnel of the school
6. Major activities of the nurse
7. Number of hours of classroom teaching
8. Health subjects taught by nurses
9. Preparation of the nurse

The questionnaire was set up in four parts as follows:

Part 1. Administrative aspects of nursing service
Part 2. Major activities of the nurse
Part 3. Contribution of the nurse to classroom instruction
Part 4. Preparation of the nurse

Questionnaires were returned from 110 schools who had filled out the blanks and from 30 schools who reported that their nursing service had been dropped. All but five of the latter had an enrollment of less than 500. Lack of funds was given whenever the reason was specified. Several schools indicated that they would resume nursing service "as soon as funds permit." Several schools had an arrangement whereby they had nursing service "on call" if needed, usually through the department of health, with reference to communicable diseases. In view of the fact that many of these schools were too small to need the full time nurse, it would seem advisable that they make arrangement with local private or public organiza-

*Health Work and Physical Education. Bulletin 1932, No. 17, Monograph No. 28, U. S. Department of the Interior, Office of Education, Washington, D. C.

tions for a part time service, since most of the schools listed were in or near large centers, where public health nurses are available.

A summary of the findings grouped under the four major parts of the questionnaire follows.

ADMINISTRATIVE ASPECTS

Among 110 schools answering the questionnaire, nurses are employed by boards of education in 80%, by boards of health in 11% and by other organizations in 8%. This is significant in view of the fact that the National Organization for Public Health Nursing has stated in the *Manual of Public Health Nursing*, that there is a decided trend today toward generalized nursing.

This study also shows a tendency for schools over 500 to depend upon public rather than private organizations for administrative support.

School nurses in these schools are directed by physicians in 34% of schools, and by a supervisor of nurses in 29%. More nurses are under the direction of a nurse in the Middle West than in any other geographical area, while medical supervision was found more frequently on the Atlantic seaboard.

The desirable standard of nurse-pupil load suggested by the National Organization for Public Health Nursing is one nurse to 1,500 pupils. This standard is probably high for secondary schools, since there are more participants in the health program of the high school than in the elementary school. Be that as it may, using this standard as a point of departure, the findings indicate a tendency for the schools of 1,000 enrollment or less to secure more nursing service than the standard, and for the schools of over 1,500 to secure less nursing service than the standard. When schools of over 2,500 secure only part time service the nurse can accomplish little by way of individual counselling of pupils, teachers and parents.

HEALTH FACILITIES

The New England and Middle Atlantic States did not report as high a percentage of parent organizations as the other sections (the figures for the South are insufficient to be significant).

HEALTH FACILITIES AVAILABLE IN 110 HIGH SCHOOLS

Facilities	Number	Per cent
Gymnasium	95	86.4
Swimming Pool	23	20.9
Cafeteria	75	67.3
Rest Rooms	71	64.5
Audiometer	32	29.1
Course of Study	57	51.8
Parent Organization	63	57.3

There is a tendency for schools of from 500 to 1,500 enrollment to have better health facilities than those smaller or larger.

HEALTH PERSONNEL AVAILABLE IN 110 HIGH SCHOOLS

Persons	Number	Per cent
Physician	84	76.4
Dental Hygienist	37	33.6
Director of Health	32	29.1
Nutritionist	26	23.6
Physical Education Teachers	101	92.0
Psychologist	26	23.6
Other Medical Specialists	32	29.1

Health personnel is distributed over all geographical areas, but the Middle Atlantic States lead in the number of physicians, dental hygienists and psychologists.

ACTIVITIES OF HIGH SCHOOL NURSES

The nurses were asked to check "yes" or "no" on a selected list of activities representing good and poor practice. The table on the following page shows those items on which there was 60% or more agreement, either in carrying out or not carrying out that activity.

EVALUATION OF NURSING FUNCTIONS

An examination of the checklist of activities reveals the fact that there was not a single item in which there was a 100% agreement in the schools studied insofar as present performance was concerned. In only 16 items was there found to be 80% or more agreement. Full agreement was not, of course, expected, nor would it be desirable, since some of the items listed represent poor practice and some good practice. Others represent good practice under one set of conditions and poor practice under an-

other set. In order to determine what is good practice and what is poor, it will be necessary to have some common basis of analysis. The reader will then make his own evaluation of procedures. It is for this purpose that these standards are suggested:

ACTIVITIES OF HIGH SCHOOL NURSES

Activity	Per Cent Agreement	
	Yes	No
1. Readmits all who have been absent		90.9
2. Readmits all who have had communicable disease or suspicious symptoms	66.4	
3. Telephones home of all absentees		88.2
4. Telephones home of all reported ill		72.7
5. Inspects all students in class at regular intervals		62.7
6. Inspects all students known to be exposed to communicable disease	83.6	
7. Assigns students to regular rest periods		71.8
8. Assigns students to rest periods on recommendation of physician		60.0
9. Personally supervises rest rooms		70.9
10. Directs others to supervise rest rooms		77.3
11. Supervises sanitation of swimming pools and dressing rooms		74.6
12. Collects samples of water from pools for tests		96.4
13. Helps set up standards of sanitation for pools and dressing rooms		78.2
14. Gives audiometer tests		73.6
15. Assists physician with regular health examination	78.2	
16. Makes preliminary examinations and refers students to physician	70.9	
17. Makes annual check-up on vaccinations and urges vaccination	69.1	
18. Makes annual check-up on teeth and urges annual visits to dentist	63.6	
19. Interprets findings of health examinations to parents	89.1	
20. Interprets findings of health examinations to teachers	70.0	
21. Interprets findings of health examinations to students	88.2	
22. Makes home calls for absence because of illness	80.0	
23. Makes home calls for correction of defects	90.0	
24. Keeps record of behavior problems and attempted solutions		70.0
25. Makes calls relative to transfer to continuation school		88.2
26. Instructs some person to be responsible for emergencies in absence of nurse	60.0	
27. Teaches regular classes dealing with health subjects		71.8
28. Attends faculty meetings regularly		60.0
29. Conducts school health committee meetings attended by members selected from faculty		80.9
30. Conducts individual health conferences with students	64.6	
31. Collects data on health examinations	68.2	
32. Collects data on communicable diseases	66.4	
33. Contributes to health education curriculum construction and revision		62.7
34. Directs health education curriculum work		86.4
35. Is director or advisor of health committees of parent organizations		81.8
36. Prepares bulletins of instruction for guidance of teachers		81.8
37. Prepares standards of sanitation for buildings and grounds		90.0
38. Signs certificates for working papers		97.3
39. Supervises health instruction by teachers		87.3
40. Supervises health instruction by nurses		95.5
41. Evaluates health texts and other health instruction materials		69.1
42. Keeps record of above consultations		66.4
43. Has regular plan of consultation with personal physician of students as needed	63.6	
44. Is a member of one or more community health committees		60.0

1. One of the functions of secondary education is to help students to acquire the knowledge, the experiences and the opportunities to become self-directed individuals. If this is accepted, then it follows that the health program of the school shall do nothing for the student which he can do for himself, or can be taught to do. He should be given opportunity to—

   a. Weigh and measure himself and record results at regular intervals.
   b. Recognize significant growth deviations and seek advice as necessary with reference to them.

c. Report to health office after illness, for advice as to fitness to mingle with others safely.
d. Report to the school an illness absence.
e. Recognize deviations from normal health and functioning in self and report to health office for advice.
f. Seek advice as to immunization measures and assume responsibility (shared with parent) for having needed treatment carried out.
g. Seek and follow advice with reference to dental care and repair.
h. Become acquainted with own assets and liabilities and take responsibility (with parent) for setting up a daily régime of living which is followed with reasonable regularity.
i. Participate in group projects for eliminating of hazards to health such as accidents and disease; and for correction of physical defects, and care of injuries.

Students should be given opportunity to control their own conduct, with reference to these and other aspects of health, under guidance of nurse and teacher.

2. In order to become self-directing with respect to the above, a student must be given such knowledge of his own assets and liabilities as will enable him to safeguard his health. All aspects of health service and supervision should be interpreted to him in such a manner that he will want to make wise decisions with reference to his daily living.
3. Since the classroom or home-room teacher is with the student more than any other member of the school personnel, many of the opportunities for practicing healthful living will be initiated by her. There is need therefore for teacher participation and responsibility in all aspects of the health program. The teacher must understand the health experiences of students, so that appropriate coördinations may be made with other materials of instruction.
4. Teacher participation should be one of the initial aims of the nurse; for it has been demonstrated in the School Health Research Studies of the American Child Health Association* that nurse-teacher rapport is one of the outstanding factors influencing health status and behavior of students.
5. Division of responsibility for various administrative aspects of the health program should be determined on the basis of fitness of personnel. If teachers are given opportunity for participation in the service program, they will often be qualified to perform some of the services previously undertaken by the nurse. This will give the nurse opportunity for more intensive work in personnel and guidance, in sex education and other aspects of health, which a well equipped public health nurse may contribute. The nurse may or may not be the member of the personnel best fitted to administer certain of the activities. If it seems necessary for her to assume the responsibility for them when not equipped, she should take steps to strengthen her background as soon as possible.
6. The school should have permanent cumulative record forms of the health of students. These should extend back into the student's history as far as there are available records, elementary and preschool periods. The nurse is obviously the member of the personnel best fitted to secure pertinent information from previous records and from personal conferences with students and parents. This information should not only be gathered—it should be utilized in understanding the development of students, in determining individual needs, and setting up instructional units.
7. The school health program should not take from the parent any responsibility which rightfully belongs to the parents, but rather should help them assume their health responsibilities intelligently.

*School Health Research Studies of the American Child Health Association. Monograph No. V., An Evaluation of School Health Procedures.

8. The health program of the school should articulate at every point with the health program of the home and the community. The nurse is the best qualified person to bring about and maintain this articulation.

WHAT SUBJECT MATTER UNITS DO NURSES TEACH?

Subject Matter Units	Number of Schools To Boys	To Girls
Nursing in the home	6	25
Care of infants and children	5	22
Growth and development of infants	5	21
Care of injuries	11	20
Prevention and control of communicable disease	7	18
Causes of communicable diseases	7	16
Causes of non-communicable diseases	7	15
Prevention of non-communicable diseases	8	13
Accident prevention in home	9	13
Accident prevention in school and community	8	12
Community resources in health promotion	5	12
Structure and functions of body	5	7
Individual assets and liabilities	6	7
Biology of reproduction	3	7
Evaluation of health literature	4	7
Vital statistics of school	4	5
Vital statistics of community	4	5

9. There are certain units of subject matter which the nurse is called upon to teach, merely by virtue of being a nurse who has knowledge of scientific facts and procedure. But this knowledge of itself does not qualify her for group teaching. The nurse who teaches classes in high school should possess the qualifications required of other high school teachers.

WHAT SUBJECT MATTER UNITS DO NURSES TEACH?

1. The nurse does some teaching in 42% of schools. The average number of hours which she teaches is 8.2 per week. In many schools she merely assists the home economics teacher with demonstrations of nursing procedures.
2. The nurse teaches more hours in the schools located in the West than in any other section, but there are more nurses doing teaching in the Middle West than in any other section.
3. More nurses are found to be teaching in schools of 1,500 to 2,000 than in any other size, though the average number of hours of teaching is much higher in the large schools than in those under 2,000.
4. In only three of the 110 schools studied was the nurse engaged in full time teaching, with no school nursing.
5. Topics most often taught by the nurse are home nursing, child care, first aid, disease prevention, and community hygiene. Sex education, evaluation of popular health literature, knowledge of one's own assets and liabilities, were among the topics the least often taught by the nurse.

PREPARATION OF THE HIGH SCHOOL NURSE

One hundred nurses replied in regard to the preparation of the nurse, as follows (see following page):

Sixty-three percent of the high school nurses in the study have some college credits, ranging from 22% with one year or less of college, to 16% who are college graduates.

School nurses seem to have had a varied experience in school nursing, with many years of experience to their credit.

SUBJECTS IN WHICH HIGH SCHOOL NURSES HAVE EARNED CREDIT

An analysis made of the subjects

YEARS IN HIGH SCHOOL AND COLLEGE

Years	High School	Per Cent	College	Per Cent
1	4	4	22	22
2	4	4	11	11
3	10	10	14	14
4	77	77	16	16
	95	95	63	63

YEARS OF EXPERIENCE

Experience	Less than 1	1-3	3-4	5-7	7-10	More
School Nursing	5	21	12	14	19	26
Other Public Health Nursing	22	20	15	7	2	3
Public School Teaching	8	3	3	5	9	0
Other Teaching	3	5	2	1	3	0

studied by high school nurses in post-graduate work for which they had earned college credit showed the following:

Subjects	Per Cent
Public health nursing	65
Educational psychology	55
School nursing	47
Child hygiene	43
Child development	42
Mental hygiene	41

SUMMARY

Among the possible suggestions for strengthening the health program of the nurse the following five points stand out prominently:

1. A high school health service and supervision program offers a maximum of educational opportunities to the student. Educational opportunities should give knowledge of and offer opportunities to participate in those health activities which the student, as a responsible adult, will be called upon to assume.
2. Relationships between nurse and teachers should give to each an awareness of the contribution of the other in terms of student health and welfare.
3. A health education program should be based on the needs of high school students. This will mean an enrichment of the content to include a much wider knowledge and appreciation of the scientific principles of health.
4. There should be a greater realization on the part of the school administrator and the nurse, of the contribution to the educational guidance program which a well trained nurse should be expected to make.
5. Closer relationship is needed between the school's health program and the health and social service program of the community. This should include a survey of community health needs and the contribution which the school can make to meeting these needs.

The Nursery School and Public Health Nursing *

By GENEVA F. HOILIEN, R.N.

A MAN in a railroad train was observed vigorously pounding a little child on the back. A fellow passenger, indignant at what looked to her like brutal beating, remonstrated with him, declaring that if he did not stop beating the child she would make trouble for him. "Madam," replied the man, "my oldest child has been expelled from school for stealing, my second child is quarantined with measles, and this youngster has just swallowed a safety pin. You can't make trouble for me!"

Every public health nurse who has been concerned with child hygiene problems has often felt as desperately helpless as the harassed father in this story. Nurses have read the glib books written by child hygiene experts and have expounded to classes of mothers what they should do about these problems, but face to face with the mother in her home, the nurse has not always been so sure of herself.

WEEKLY CONFERENCES

Realizing that a nursery school and a public health nursing organization should be of mutual help, these two agencies in Albany decided in the fall of 1932 to "get together." The staff of the nursing organization was given opportunities for observation in the nursery school (which is under the local Board of Education) during its morning sessions. The student nurses affiliating for public health experience are placed in the school for a week. The nurses become familiar, of course, with the routine procedure of the school, but the most important contact maintained between the two organizations is that of a weekly discussion conference, conducted by the nursery school director with the staff of the nursing organization. To these conferences are brought the nurses' actual problems, such as this one:

Mrs. Smith was expecting her seventh baby. The oldest child in the family was Timmy, a boy of twelve, who was the father's child by his former marriage. Larry, eleven and a half, was the mother's by her former marriage; as was Jane, nine years of age. The three younger children had been born of the present union. When the nurse made her first visit to Mrs. Smith for prenatal instruction and care, she immediately divined a most difficult situation. Timmy and Larry were both inclined to laugh knowingly, yet withal rather sheepishly, when their mother told them to take the younger children with them to play in the backyard while "mother talked to the nurse." The home was very crowded and congested and yet Mrs. Smith was planning to be delivered at home. The nurse realized that, in order to maintain any semblance of wholesomeness and mutual respect among the members of this family, she would have to aid Mrs. Smith in talking to the children in regard to the coming of the new baby—a task which the mother felt entirely beyond her and in which, may I add, the nurse felt equally helpless.

Because this whole problem seemed so pressing, it was decided to use it as a basis for the discussion between the nursery school director and the public health nursing staff. I know many of you will immediately say, "Another discussion of sex," but as public health workers, we must face the fact that sex education is not a thing apart from other health education and not a thing that separates itself from other phases

*Read before the Child Health Section at the annual meeting of the American Public Health Association, Indianapolis, Indiana, October 10, 1933.

of living. In the crowded homes of today, children must be helped to develop a dignified and wholesome attitude towards all phases of life. As Karl de Schweinitz* has written: "Sex education is inevitable. Children are born without either facts or point of view. They reach adult years with both. To bring this process of acquisition within the bounds of method, even though the secret of that method be its informality, is to place it in the way along which all scientific progress has been achieved. This, together with the clearing of the mysteries and the ignorances that puzzle and give anxiety to the child, is sufficient reason for sex instruction. We can rest our case with the comment received by one mother: 'You have told me things I have wanted to know for a thousand years.' "

And so, the Smith family problems became the basis for our first discussion class.

Nurses, as do mothers or other groups of people, sometimes make miserable failures of their work with children because they themselves lack the emotional balance which is basic in dealing with people, especially children. However, a sound lesson in patient and slow reasoning was taught by the discussion leader as she gradually cleared away the emotional difficulties in the way of frank discussion of this problem. The outcome was this: that sex instruction is being incorporated in the prenatal visits made by our staff nurses. To be sure, this is not possible in a wholesale fashion. The millennium is not yet here, and many mothers cannot bring themselves to talk to a public health nurse, much less to their children, about their feelings on the subject of sex, but in the case of the Smiths, the mother was aided in discussing with the older children the fact that she was to have another baby, that it was to be born at home, and that, further, they were to be given opportunities of assisting in the preparation for its coming. They helped to mend the crib, for instance, which gave them a sense of real interest in the new baby. Other tasks were found for them to make them feel a real responsibility in the matter.

The aspects of our prenatal visits are as varied as our actual number of mothers. For the nursing staff, our discussions have led to a great deal of study and reading, and thought and ingenuity, but all agree that the best result is to make them feel more adequate in meeting the needs of their prenatal patients and, what is equally important, the conferences have helped them personally.

OTHER TYPES OF CASES

Have you ever heard of a child, especially an only child, who refuses to eat his meals? This was another problem which came for discussion to our weekly conferences. In a few instances, it seemed advisable for the nursery school director to meet the mother in the case personally. These visits were of real help to the individual nurse, too. I cannot go further without saying that much credit must be given to the nursery school director, who has, what the Spanish would call a remarkable "gift for people."

One of the fields in which nursery schools have been of particular value to children and parents has been that of play. In the past, public health nurses have not been at all concerned with children's toys. In fact, they have given the subject little, if any, serious thought. And yet, if we are to believe our child psychologists who have given much study to the matter, the selection of a child's toys has much to do with the molding of his habits, both of thought and action. We found in talking to our staff that few of them knew anything at all about the subject. Therefore, time was given in our weekly conferences to the matter of toys, or work tools for children. Again actual cases were brought up. There was Mary, who was never satisfied to play with any of her toys for longer than three or four minutes at a time. It was found, of course, that she was given all of her playthings

*de Schweinitz, Karl, "The Dangers and Advantages of Sex Instruction for Children." Mental Hygiene Quarterly, July, 1931.

at "one sitting," as it were, without regard to their variety or choice. There was Johnny who never seemed to want to do anything but pound nails into the floor or something equally destructive. His father was given an opportunity to visit the nursery school to see the type of large blocks, etc., which he himself could go home and make, so that Johnny would have the sort of playthings which would satisfy his longing to "make big things."

During the year almost every problem with which children can confront their parents was brought to our discussion group. Needless to say, they were not all settled or cared for, but at least there was frank and often heated discussion of them. Our plans for the coming year will continue to concern the emotional and physical relationship in the development of good physical and mental health habits. The aim will be to help to motivate mothers and children actually to practice good health habits. After all, it is not enough that mothers can give the right answers to the nurse's questions when she asks what foods Johnny eats. Johnny must be eating them.

Public health nurses cannot be experts in all phases of health instruction in today's pressure of work and in today's trend towards generalized health nursing. Therefore, I believe, we should take advantage of any resources available in our communities for the development of any particular project. George A. Hastings has said: "The child has three parents: mother, father, and the community. The precocious child who explained her mother's first place in her affections on the theory that her mother was related to her by birth and her father only by marriage, probably would add that the community came into parental relationship by adoption. In reality, the community has come into the parental triumvirate through the necessities and complexities of modern life."

We feel, in our community at present, that child hygiene, especially of the preschool child, needs to be developed. It is for this reason that we have allied ourselves with the nursery school, knowing that this organization can give us stimulation, inspiration, and guidance in the emotional and mental problems of childhood in our city.

LEADING ARTICLES IN THE AMERICAN JOURNAL OF NURSING FOR MAY, 1934

A Guide to Growth

This chart was prepared by Mrs. Frances J. Campbell, one of the nurses on the staff of the Association for Improving the Condition of the Poor, 105 East 22d Street, New York City, and may be purchased from there for 5 cents. It is a guide for noting child progress in family health service. It has been developed by consultation with recognized pediatricians and text-books on pediatrics. Of course it is understood that orders from private physicians or clinic physicians, under whose care any children may be, take precedence over these guiding suggestions. Where items regarding controversial matters have been indicated, the conclusions are those approved by the U. S. Children's Bureau.

AGE	3 MONTHS	6 MONTHS	9 MONTHS
	Phys. exam. once a month.	Complete phys. exam. bi-monthly. Toxoid. Vaccination.	2 teeth. Phys. exam. bi-monthly.
HEIGHT	Av. 24" (20-28).	Av. 26". (21-31).	Av. 28". (23-33).
WEIGHT	Av. 13 lbs. (9-17). Weigh weekly.	Av. 16 lbs. (11-21½.) Double birth weight. Weigh weekly.	Av. 19 lbs. (13½-23½.)
DIET	Breast or formula q4h or q3h. Water—cereal water between feedings. Vegetable water. Orange or tomato juice bid. CLO bid.	CLO bid. Orange or tomato juice bid. Cereals. Egg yolk—limited amount. Puree of green vegetables Spinach Carrots Green Peas Lima beans Beet green Asparagus Breast feeding q4h during the day. Substitute one feeding with formula. Water	3 meals a day. Milk in afternoon. CLO bid. Orange or tomato juice in the morning. Baby should be *weaned*. Water. Quart of whole milk. Cereal. Egg yolk—limited amount. Baked potato. Green vegetables. Stewed fruit—apple sauce, prune pulp, apricots, and peaches.
SLEEP	Sleep 22 hrs.	Sleep 16-18 hours. Nap both A.M. and P.M.	Sleep 16-18 hrs. Nap both A.M. and P.M.
HABITS	Begin bowel training at one month. Sun-bath at 3-4 weeks. Give daily exercise—feet, arms and legs.	Sun-baths—sleep in sun if possible. Continue with bowel training. Start training for bladder control.	Continue training for bowel and bladder control. Drink out of a cup.
DEVELOPMENTS	Muscles stronger. Vigorous kicking. Holding up of head if body is supported. Discover hands. Recognize parents.	Sit up with support. Turn over. Begin to crawl. See small objects. Reach for objects with both hands. Laugh at sights and sounds. May show consciousness of strangers.	Teach to hold cup. Sit alone and erect—crawl. Pull up on a chair or side of play-pen. Pick up toys that have been dropped. Reach for object with one hand. Recognize people by sight and voice.

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AGE	1 YEAR	2 YEARS	3 YEARS	4 YEARS	5 YEARS
	Phys. exam. every 3 months	Phys. exam. every 6 months Fontanelle closed.	Phys. exam. twice a year.	Phys. exam. twice a year.	Phys. exam. twice a year.
HEIGHT	30″ (25-35)	33″ (29-40)	Av. 36″ (31-44)	Av. 40″ (33-46)	Av. 43″ (36-49)
WEIGHT	Av. 21 lbs. (15-28) 3 times birth wt. Weigh once a month.	Av. 26 lbs. (20½-35) Weigh once a month.	Av. 30½ (23-40)	Av. 36 (25½-42½)	Av. 39½ (30½-47½)
TEETH	6 teeth	16 teeth Dental exam. every 6 months.	20 teeth, all first. Dental exam. twice a year.	Dental exam. twice a year.	Dental exam. twice a year.
DIET	1 quart of milk. CLO bid. Orange or tomato juice. Egg yolk. Baked potato. Stale bread and butter. Green and other vegetables. Cooked fruit (strained) Cereals. Cream soup. Scraped beef (if desired). Minced liver. Crisp bacon. Mashed, ripe banana. Water.	1 quart of milk. CLO bid. Orange juice. Boiled or baked potato. Macaroni. Cereal. Dark green vegetables (pureed). Other vegetables. Stewed fruit. Raw fruit: Peeled apple Banana. Milk puddings. Scraped beef. Chicken (minced). Liver. Fish. Bacon. Egg(whole). Water	1 quart of milk. CLO bid in winter. Orange & tomato juice. Cereals. Mashed sweet potatoes. Cooked vegetables Raw vegetables (shredded): Carrots Cabbage Raw fruits (skins removed). Cooked fruit. Meats: Lamb—minced. Chicken. Liver. Beef. Custards. Egg. Ice-cream. Water.	Diet same. CLO bid (winter) 1 quart of milk. Water.	The same. CLO bid (winter) 1 quart of milk. Water.
SLEEP	13 hours sleep at night. Nap in A.M. and P.M., 1 hour outdoors if possible.	13 hours sleep at night. Nap in A.M. and P.M. 1 hour.	11-13 hours. sleep at night. 2 hour nap in day or 1 hour in A.M. and P. M.	11-13 hours sleep at night. 2 hour nap in day.	11-13 hours at night. 2 hours a day.
TALK	Several words (associate word with person or object.)	Name animals and familiar objects. Use single sentences and phrases.	Full sentences. Carries on a conversation about play. Uses pronouns, past and plural.	Tells about play and other happenings. Uses descriptive words with pictures.	Sentences. Tells about play. Tells fantastic stories.
HABITS	Complete bowel control and beginning to learn bladder control. Outdoors 3-4 hrs. in winter, 5-6 hrs. in summer. Holds a cup for drinking.	Bladder control during the day. Outdoors 3-4 hrs. in winter, 5-6 hrs. in summer.	Control of bowels and bladder, both night and day. Wash hands and brush teeth. Put toys away. Outdoors 3-4 hrs. in winter, 5-6 in summer.	Dresses and undresses. Buttons clothes if buttons are within reach. Care for clothes at toilet. Feeds self—can cut food fairly well.	Dresses and undresses without help. Eats alone and uses knife and fork. Goes to toilet alone.
PLAY	Plays alone. Imitates simple acts.	Includes others in his play. Imitates. Piles blocks. Uses a pencil and scribbles on paper. Puts pegs in board. Likes to play in sand, filling and emptying.	Plays with other children. Strings beads. Draws and pastes pictures. Builds bridges.	Plays with several children and takes part in the play. Play becomes imaginative. Uses scissors to cut out pictures. Makes up games. Likes same stories.	Draws pictures in detail. Cuts with scissors and pastes pictures Likes to pretend and dress up. Imitates things he sees done. Plays and works with other children
DEVELOPMENTS	Creep and pull up on a chair. Stand with support. Use hands and play with blocks and ball. Hold cup and spoon. Pull off stockings. Understand when spoken to. Walk at 12-17 months.	Run well—get up and down on floor without holding on. Good equilibrium. Pull off stockings. Help with dressing and undressing. Feed self, spilling some. Like music and rhythm. Put toys away. Can operate a kiddie car around a chair.	Very active—runs, jumps and climbs; good balance. Tries to dance to music and sing. Rides tricycle well. Powers of concentration fair—interest changes. Helps with dressing & undressing. Takes off hat and coat and hangs on a hook. Unbuttons clothes (big buttons). Puts on shoes.	More expert at climbing. Balance good. Concentration better—able to repeat stories. Able to differentiate in colors.	Skips and dances. Climbs ladders and trees. Turns somersaults. Throws a ball well. Powers of concentration good; likes longer stories. Wishes to learn to read; repeats verses read. Colors named.

Nurse-of-the-Month

DOROTHY V. SMITH
INDIANA

Just another Smith; graduate of the Methodist Episcopal Hospital, Indianapolis, Indiana, with nine weeks' student training with the Public Health Nursing Association in Indianapolis before graduation. Experience since graduation: three months' private duty, school nursing, county nursing, city and school nursing, and now five years' school nursing in Valparaiso, Indiana. Twenty-four weeks' work toward a degree in Public Health—twelve weeks at George Peabody College and twelve weeks at Iowa University.

The Board of Education of Valparaiso, with the approval of the Parent-Teachers Association and other allied civic organizations, employed a school nurse for the first time in August, 1929.

Valparaiso, with a population of about 9,000, while a city of home owners, with very few foreigners and no Negroes, has a big relief problem due to the number of our citizens now unemployed who worked in the nearby industrial Calumet region. The nurse, being very familiar with the actual home conditions, helps with relief problems. Recent federal relief supervision has lessened this work for the nurse.

Valparaiso is fortunate in that there is very little turnover among the members of the school faculty; most of the teachers have been here from fifteen to forty years and consequently really know their community. This helps in any community work and is a great aid in health education projects. A health program should be a coöperative community program and will be successful only so far as the teachers, parents, children, and citizens of the community work together. Newspaper articles, talks to civic groups, bulletins, etc., are used to keep the teachers, parents, and all informed as to current health conditions. We feel that the teachers and parents are just as vitally interested in the pupils' health as the nurse.

Parents are more than willing to coöperate when they "know why." In case of an exposure to a contagious disease in one or more of our school groups, mimeographed letters are sent to the parents of this group telling of the exposure to the contagion, school procedure, and symptoms parents should watch for. These letters also describe the home care necessary, the period of incubation, the need of a physician's care, and urge that the sick child be kept at home and follow common sense health rules. Teachers' bulletins carry this same information when groups have

been exposed. General bulletins deal with more general health education problems and classroom procedure. This type of educational work seems at the end of five years to have resulted in good attendance and few epidemics.

Physical inspections are done on a screening system—first, third, fifth, eighth grades, physical education classes, and special cases—each year. Reports on these, given the teachers, are put into non-technical terms. Junior high and high school teachers receive this report for incoming seventh and ninth grade pupils each year. Each principal also has a copy of all reports for the building. Teachers correlate these reports with their health lessons and in their discussions with the parents about pupils' school work. This plan results in as many corrections as the nurse's home visits. Many parents come to school to be present at the physical inspection. Needed corrections usually follow these visits.

The permanent health record card is kept in the nurse's office. On this is a semi-annual record of the child's height and weight, record of physical inspections, home calls, and special conditions. These cards are filed alphabetically for each building. Colored metal tabs are used to indicate records of pupils needing special attention, a yellow tab indicating need for watching nutrition, green—vision defect, black—hearing defect, blue—excused from physical education by physician, and red—special attention needed. These colored tabs make it much easier to keep these children under care, lessen record work, and make the records easier to use for publicity work.

Teachers weigh their pupils monthly, using an individual weight graph. Children showing a loss over a period of three to four months are reported to the nurse and home calls are made. The children are especially interested in the comparison of this year's weight with last year's, and this, when correlated with the classroom health lessons, teaches many a valuable habit. Seating arrangements are checked each semester to see that the child is comfortable and that vision and hearing defects are considered.

Valparaiso has no regularly employed school physician. The health program is a coöperative one with the sixteen local practicing physicians. Each physician furnishes standing orders. All agree on orders for first aid and emergency cases.

Home calls are made when necessary and usually average about seventy-five a month. As we have no attendance officer now, the nurse makes extra calls investigating and checking attendance problems.

Health interest is very active in the girls' physical education department. Each girl is inspected each semester before taking physical education. When an unusual condition is found, she is requested to see her family doctor for a complete physical examination and a certificate which will either allow her to participate in activities or excuse her from them. The nurse usually consults the parents and doctor. In Indiana credit in physical education is necessary for graduation, unless the student is physically unfit. The Valparaiso Girls' Athletic Association creates and maintains a great deal of interest in health conditions.

Through a Civil Works project, a clerical worker was put in the nurse's office to make a study of the records as a means of measuring the results of school nursing activities as outlined in Miss Randall's article in the September, 1933, issue of PUBLIC HEALTH NURSING. We are eager to complete this material for study. We also hope to make a study from past records of the causes of absence.

It is the school policy here that anything affecting the child's health is the business of everyone—superintendent of schools, principals, teachers, janitors, pupils, parents, taxpayers, and nurse. Only by constantly working together will we gain our ideal—"children with a sound mind in a sound body."

Salaries of Public Health Nurses in 1934

By ANNA J. MILLER

Statistician, National Organization for Public Health Nursing

THIS report on salaries paid in January, 1934, to public health nurses is based on the replies to a questionnaire sent to 440 agencies (both public and private) in various parts of the country. The data are presented in slightly different form this year, much of the detail having been omitted. It is felt that the information given will answer the requirements of most of our readers. However, more detailed information is available in our office, and we will be glad to furnish it on request.

Information received from 377 organizations was included; this total of 377 is approximately equally divided among health departments, boards of education and private nursing organizations. The actual distribution is:

Public health nursing associations	134
Health departments	118
Boards of education	125

The total number of nurses employed by these agencies is 6835. This number includes nurses employed by the three types of agencies in the following numbers:

Public health nursing associations	2,599
Health departments	3,083
Boards of education	1,153

What one wants to know about salaries for a specified position is, what is the prevailing salary rate, or another way of stating this, what is the usual rate. Statistically speaking, this figure is the "mode" for the group. For this reason the "mode" has been used, for the most part, in this discussion.

Considering salaries paid to field nurses, we find that on the basis of salaries reported as paid to 4,944 employed by either a health department or private organization, the mode is $120 per month. More than three-quarters of the nurses engaged by health departments receive more than $100 per month; in other words, salaries under $100 are comparatively infrequent. Half of the health department nurses receive more than $125. In the private organizations, $120 is the most usual salary, and almost half the nurses are paid more than that. Only one-quarter of the nurses in these agencies receive more than $125, as compared with fifty per cent of those in health departments.

A further analysis of field nurse salaries in health departments and public health nursing associations has been made to determine the salary mode in cities grouped according to size of population. The results are as follows:

SIZE OF CITY	MODE	
	Health Dept.	Public Health Nursing Assn.
1,000,000 and over	$135	$135
500,000 to 1,000,000	120	120
250,000 to 500,000	125	120
100,000 to 250,000	115	120
50,000 to 100,000	105	120
25,000 to 50,000	115	120

The data for cities of less than 25,000 are not complete enough to be included in this analysis.

A comparison of salaries paid to staff nurses in the various geographic sections of the country is of interest. The mode for the five large divisions is as follows:

SECTION	MODE		
	Health Dept.	Public Health Nursing Assn.	Both
New England	$130	$120	$120
Middle Atlantic	115	110	115
South	100	100	100
Middle West	100	120	100
Far West	150	125	135

Arranging the sections from the highest to lowest for both types combined, we have the following:

1. Far West
2. New England
3. Middle Atlantic
4. Middle West
5. South

The usual annual salary for a school nurse is $1,700 a year. This figure is

based on salaries reported for 1,840 school nurses employed either by health departments or boards of education. One-quarter of the school nurses receive more than the usual $1,700 salary. An analysis of school nurse salaries in cities of various size yields the following:

SIZE OF CITY	MODE
1,000,000 or over	$1,700
500,000 to 1,000,000	1,600
250,000 to 500,000	1,400
100,000 to 250,000	1,300
50,000 to 100,000	1,200
25,000 to 50,000	1,600
Less than 25,000	1,500

The salary mode of a school nurse in various parts of the country ranges from $1,700 in the Far West to $1,000 in the southern states. Arranging the sections in the order of highest salary first, we find that the order is Far West, Middle Atlantic, New England, Middle West, and South, which is practically the same as that obtained when the salary of the field nurse employed by public health nursing associations and health departments was considered.

In the consideration of administrative salaries which follows, median* salaries have been used, as the number of director and supervisor salaries which are available is too small a group for a mode determination. The median salary of the director is presented for organizations grouped according to the total number of nurses on the staff.

For both health departments and private organizations the salary varies directly with the size of the staff; the median salary of director of nursing in a health department is lower than that of the director of a private public health nursing organization of the same size staff:

Size of Staff	Health Dept.	Public Health Nursing Assn.
100 and over	$210	$330
50 to 100	200	315
25 to 49	180	225
10 to 24	160	210
2 to 9	140	165

Supervisor salaries for both types of agency, using the median as a basis of comparison, would indicate a slightly higher figure for health departments, in which the median is $150, while it is $145 in the private agency.

The median salary of the supervising or chief nurse in a department of education is $1,760. This figure is based on salaries reported for 40 departments in which a school nurse director is employed.

It is encouraging to note that increases in salary were made on January 1, 1934, in 28 organizations, 16 of which are health departments and 12 public health nursing associations. This includes one private agency in which the increase took the form of a bonus. In addition, 9 report that increases are planned during the year, the date having been definitely fixed upon. A larger number, 19, state that increases are expected, but at the time of returning the questionnaire, a definite date at which this would take place could not be given. Other favorable indications are additions of staff personnel and plans for longer vacations with pay.

*The median salary of a group means that the number of persons in the group receiving less than that salary is the same as the number receiving more than that salary.

Evaluating Methods of Supervision

By HAZEL HIGBEE, R.N.

AS a second year student in the twenty-one months program of the course in public health nursing at Western Reserve University in Cleveland* the writer was interested in studying the relative values of various methods of supervision. In an attempt to evaluate from the point of view of the staff nurse the methods of supervision used in the Cleveland Visiting Nurse Association, a questionnaire dealing with these various methods was given to twenty staff nurses in December, 1932, with an explanation of the objective of the study. The selection of the nurses to whom the questionnaires were given depended upon varying lengths of service with experience in different sub-district offices; diversity of previous experience; and differences in degree and extent of training in public health nursing. The first group of questions dealt with the methods of introducing the new nurse to the field and her evaluation of these methods. The second group pertained to the office routine, while the subsequent groupings dealt with particular methods of supervision—as field visits with the nurse, reading of records, individual conferences, group and staff meetings. The last group referred to the personality and abilities of the supervisors. In giving this summary only the major points in supervision have been considered.

The twenty nurses selected had served on the staff from eight months to thirteen years, the average length of service being five years. Fifteen of these nurses had had previous experience ranging from one month to six years before coming to the Cleveland Visiting Nurse Association. Of these, however, the majority had had but two or three months in a public health nursing agency as student nurses.

The purpose of supervision as expressed by the group was: To efficiently execute a definite program; to secure systematic routine and uniformity of procedures; to give guidance and inspiration and to direct the development of the abilities of the individual nurses.

INTRODUCTORY PERIOD

Some of the group felt that supervision was too close during the introductory period to allow ease of adjustment, that there were too many details in technique and that it was difficult for the nurse to know just what was expected of her. The majority, however, expressed a favorable reaction—the nurse did not feel hurried, responsibility was given gradually yet the nurse felt that she was being entrusted with an important piece of work.

With the exception of four nurses who had been on the staff over eight years all were given office demonstrations of procedures. These four received demonstrations in the home but would have preferred to have had them in the office. It was the opinion that office demonstrations are of great value to the new nurse. They give her an idea of the scope of the work, a visualization of the home set-up, practical suggestions on how to improvise with home facilities, and later a feeling of confidence that she is carrying out procedures correctly. Demonstrations help to maintain a uniformity that prevents families comparing unfavorably the procedures of one nurse with those of another. It was suggested that time should be allowed after each demonstration for the nurse to become familiar with that technique before a new one is given; also, that care should be taken not to overestimate equipment to be found in the home.

Home visits with the new nurse by

*The twenty-one months program of the course in public health nursing in Cleveland is a joint program of the School of Applied Social Science of Western Reserve University and the Cleveland Visiting Nurse Association

the supervisor or her assistant seemed to be most satisfactory when made after the nurse had had one or two weeks alone in the district. Some suggested that one visit be made during the first week and then the nurse be given three or four weeks alone. Another suggestion was that the new nurse be given more opportunity to observe with an older staff nurse. (The new nurse usually visits with an older staff nurse for three days.)

The chief difficulties in the organization during the first month were listed as: organizing work to avoid waste of time, establishing self in the district, obtaining social data, securing remuneration from patients, becoming familiar with the details of records, dictating to a stenographer,* and contacting other health and social agencies.

PRESENT DIFFICULTIES

In discussing present difficulties the problem of recording was mentioned most frequently. Many were concerned with knowing how and what to record and had a feeling of being hurried with their record work. Some suggestions for overcoming these difficulties were a regular time for each nurse not only to dictate but to organize her material for dictation. It was the opinion of some that a schedule for short consultations with the supervisor would avoid interruption of record work. According to the desires expressed, ideally, every office should consist of at least two rooms. The stenographer should have a separate room and many suggested a third room where the nurse and supervisor could hold conferences.

Some of these nurses still have difficulty in securing fees from patients. Lack of time to do health supervision and prenatal calls satisfactorily was frequently mentioned. Others listed such difficulties as securing coöperation of the family, giving nursing supervision without making the family dependent, recognizing and considering emotional problems, and making health teaching constructive in the very poor homes.

HOME VISITS

As judged by the staff nurse, the supervisor's reasons for making home visits were to inspect procedures, to observe the nurse's ability to improvise equipment, to keep in touch with the difficulties under which the nurses are working, to become acquainted with the nurse as well as with the patient, to observe the nurse's approach, her attitude toward the patient and the attitude of the family toward the nurse, and to judge the ability of the nurse to carry on in that particular type of district.

The main disadvantages of home supervisory visits appeared to be: the home atmosphere becoming unnatural—the patient becoming self-conscious or resenting what she considers "checking" on her nurse; and the nurse finding it hard to be absolutely natural and to do her best work under such conditions. Other disadvantages were that field visits take much of a supervisor's time and in order to have her see definite cases a poor arrangement of the nurse's work for the entire day from the point of travel time may be necessary.

The advantages listed were: the supervisor becomes acquainted with the patients, the travel time, and the time required to give the nursing care; she is more aware of the difficulties involved in certain situations and is often able to present a different point of view, suggest a simpler procedure or a more effective method of improvising. It was pointed out that it is not always sufficient for the supervisor merely to remark that a procedure might be more simple but that she should give some definite suggestions. Many expressed the opinion that the greatest value of these visits is the opportunity to have the supervisor alone and talk over other problems—problems, perhaps not dealing with the particular case the supervisor is going to see but problems in general. This desire to talk over difficulties has motivated many a request for a field supervisory visit. These visits afford the supervisor an opportunity to give an occasional word of

*In Cleveland the nurses dictate their reports to a stenographer in the office.

praise which is stimulating to the nurse. If the nurse is having difficulty interviewing patients, the supervisor may in a very natural way carry on a conversation while the nurse is giving care. In this, however, there may be a threat to the security of the nurse in the home if the supervisor usurps the place of the nurse by taking the initiative. This was brought out by citing a visit during which the supervisor carried on the conversation with a new patient and settled all but the fee, which made for misunderstanding between the family and the nurse.

The cases which the nurses prefer to have the supervisor visit are those for bedside care—the most desirable being postpartum cases. The majority do not like the supervisor to call on a new case—especially a prenatal. Neither do they prefer her on a health supervision case, on cases where it has been difficult to establish confidence, or where the patient is emotionally unstable.

The frequency of supervisory visits should depend primarily on the nurse, the type of case and the character of the district. If the quality of the work of the nurse is in doubt or if the supervisor sees some difficulty that she thinks she can clarify by seeing the patient, then a home visit should be made.

Suggestions given that might be helpful to the supervisor were: enter into but avoid monopolizing the conversation; reinforce the statements of the nurse when advisable; assist the nurse when convenient; stay in a patient's room when care is being given only when you can assist in some little way; allow sufficient time for the visit so that the nurse need not feel hurried; make some comment regarding each case; do not try too hard to make the nurse feel comfortable, and give her an opportunity to direct the conversation while traveling from one case to another.

INDIVIDUAL CONFERENCES

Individual conferences with both the supervisor and mental hygiene supervisor have been very helpful in creating a better understanding between the supervisor and nurse as well as in establishing self-confidence in the nurse. Other advantages of these conferences were: an appointment makes the nurse feel that her problem is being given individual attention; discussion is free and easy and she must of necessity take part. It was suggested that the supervisor approve of the plan of the nurse if it is workable, if it is lacking in some respect the nurse would like suggestions for improvement. Conferences help the nurse to see the importance of a plan for the family rather than for the patient only; the basis for the selection of health supervision cases; the emotional factors as they complicate illness; the advantages of accurate recording of observations; and the necessity of contacting other social agencies. Some disadvantages listed were: if friction exists between the supervisor and the nurse conferences may increase the tension; there may be a tendency on the part of the nurse to submerge her own ideas and accept those of the supervisor; sometimes it is difficult for the nurse to plan her work so as to be in the office at the given time. Where the supervisor is free in the mornings some nurses are satisfied with irregular consultations while others expressed a desire for regular appointments for conferences.

Most of the nurses reported that they have a definite plan for the difficult case in mind before they present it to the supervisor for advice. Some have only a knowledge of the case history and agencies active while others have tried several plans before going to the supervisor. The group felt that a conference on a closed case is helpful if the case is chosen because it is typical or similar to an active case.

SUPERVISION THROUGH RECORDS

Supervision through records has been helpful in stimulating individual analysis of work, keener observation and more adequate recording. Several expressed a dislike of receiving suggestions in the form of notes attached to their records. They preferred conferences, and these early. Help received through the studying of records by the supervisor has been in the form of sug-

gestions for selecting important facts, condensing the recorded material, and an idea of what information should be given to other social agencies. The majority of the group liked record work because they found the records to be simple, concise, and interesting; yet many expressed a desire for more time and quiet.

STAFF MEETINGS

The types of staff meetings finding preference were lectures on newer methods of treatment and drugs; work of allied agencies; a series of related subjects on mental hygiene or the preschool child; demonstrations of technique and presentation of current topics.

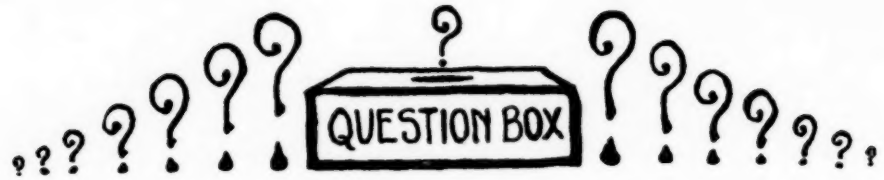
It is the policy of the Cleveland Visiting Nurse Association to hold group meetings weekly in each branch office. The supervisor, mental hygiene supervisor, and staff nurses coöperate in planning these meetings. It was the opinion of the group that these meetings have been of value to the individual nurse in helping her see the problems of her co-workers, their points of view and their methods of handling their problems. These meetings have been a factor in stimulating the nurses to think and read more and offer the supervisor an opportunity to understand the interests, attitudes and needs of her group. It was the opinion that these meetings were most stimulating and beneficial when they are planned in relation to the needs of the group, when the topics are announced in advance and when the supervisor and nurses coöperate in assuming responsibility for certain parts of the series.

WHAT METHODS ARE MOST VALUABLE?

The nurses were asked to list all these methods of supervision in the order of their value to the individual nurse. Fifteen of the group considered individual conferences to be of the most value and the majority of the others placed them third. Records were considered second in value by ten, and third or fourth by the majority of the others. Group meetings were placed fourth by ten and second or third by eight. Staff meetings were placed fifth by eight and third or fourth by ten. Field visits were placed second by six, fifth by seven, and third by the majority of the others.

The qualities of the supervisors which have been an inspiration to the nurses were given as: optimistic philosophy, high ideals, understanding, a spirit of helpfulness, friendliness, interest in the nurse's general welfare, and above all a confidence in the ability of the individual nurse.

—Courtesy of the Infant Welfare Society, Minneapolis, Minn.



QUESTION:

What is the policy of other public health nursing organizations in referring patients to maternal health clinics?

ANSWER:

Information has been received from 43 organizations regarding this question:

Agencies in which the question has not been raised—7

Agencies which have a definite policy against referral of patients to clinics—4

Agencies having a policy of referral to some source of help—17

Types of policies:

a. Nurse may refer patient directly to a doctor or clinic

b. Patient is referred only in case of physical reasons

c. Nurse may refer cases except those who may have moral or religious objections

d. Only refer cases when patient asks for information

e. Case may be referred through a social welfare organization, such as a family welfare agency or associated charities

Several agencies report that it is not the province of the nurse to make such decisions. Information should be left to the doctor's discretion.

QUESTION:

If only one visit can be made to a preschool child between the ages of one to six years, when should the public health nurse visit and what should she teach?

ANSWER:

In answering this question we asked three staff nurses to give their answers:

From Velma M. Owen, Anniston, Alabama:

Since the preschool age is medically known as the "neglected age," I would say that the most important age to visit the child is around four years. The parents need help at this time and are advised to keep up a close watch and careful observation of the child so that he may maintain his good start.

I would, first of all, try to make a satisfactory approach. Assuming that I had gained the confidence of the mother and had been received as a friend, I would first tell her the advantages of living in the country. Then I would approach the subject of the importance of a physical examination by the family physician. It is difficult to convince parents of the importance of an examination of the child that is apparently healthy and hearty. At this point I would try very hard to make the mother see the great importance of keeping the child well.

I would go into detail concerning the importance of proper nutrition, pointing out the difference in the child's food needs as compared with those of an adult and discuss the choice and preparation of available foods.

I would explain the great importance of protection against communicable diseases, particularly diphtheria, smallpox, and typhoid, and urge obtaining such protection from the family physician or health department.

I would try to explain that the child is an individual and can be appealed to in various ways and can be interested in carrying out the every-day health habits without harsh discipline.

The importance of the father's interest in the child, as well as the mother's, and his assuming the responsibility on a fifty-fifty basis should not be overlooked.

Because there is so much and of such importance that the mother should be told on this one visit, I should try before leaving to summarize it for her in simple language so that she could remember the essential things concerning the child's welfare.

Last but not least, I should try to convince the mother of my deep and sincere interest in the individual child, and ask her for a report on the child after he is examined and has been protected against the above mentioned diseases. Well chosen literature left in the home will be a reminder of my visit and help her recall my suggestions and advice.

From Mrs. Edna Paulsen, Visiting Nurse Association, Milwaukee, Wis.:

If the public health nurse is able to make only one visit to a preschool child the most desirable time would be when that child is two years of age. Careful supervision of the infant

during the first year has given the mother the fundamentals of infant care. The prevention, nature, and care of communicable diseases have been greatly stressed and prophylaxis administered.

After the child has started to walk, attempted feeding himself, and has encountered difficulties in social adjustments, the mother doubtless will have many bewildering problems and will need wise guidance and help. To attempt making a statement of the teaching to be undertaken on this one visit would seem to be entirely impossible as an analysis of the mother's and child's needs would necessarily determine the procedure which the nurse must follow.

The visitor would first carefully observe the physical development of the child, note any possible defects or abnormal condition, and plan with the mother regarding necessary medical attention. Good health is definitely related to habits of living, therefore a careful survey of the child's habits is made.

Eating habits, with emphasis placed on well balanced meals, careful introduction of new foods and the early effort to teach the child to help himself; sleep at night for eleven to fourteen hours and rest during the day; careful watching of elimination habits; daily care of the teeth and the first trip to the dentist planned when the third birthday has been attained; the value of regular habits; the protection from and treatment of colds—and also other diseases of childhood.

One quickly realizes that a great deal of time would be required to discuss at length each of the above points. It would be well to provide the mother with helpful literature pertaining to her special problems and guide her reading into the channels where help could be found.

Every mother wishes her child to be possessed of a well rounded, likeable personality. The building of character requires careful thought and effort. Early the child must learn to make decisions for himself, must learn to adjust his conduct, and build standards which shall help him to stand on his own feet and meet the bigger problems in later life situations. At this age the mental training is even more important than the physical direction. The emotional development also requires special guidance in such a way that the child is helped to develop a personality that is acceptable to society at large. Good habits are easily taught. Imitation and suggestion are important factors in their development. Persistency and consistency are essential—and above all the child needs a home atmosphere of tranquillity and peace.

The nurse who brings to her task scientific knowledge, keen insight, and an understanding heart, will give to the mother information that shall provide a good foundation for child growth, a vision of fine ideals, and courage to do the task well.

"We should be showing ourselves less generous than the cavemen, if, now that our turn has come, we did not strive to make life better and more secure for our children than it is for ourselves. To achieve this end, two things are indispensable, knowledge and love; for with knowledge and love the world is made."*

From Florence Race, Visiting Nurse Association, Milwaukee, Wis.:

It has been said that a month out of the life of a preschool child may be equal to many months in the life of an adult. I feel that a child at the age of two years has reached a big turning point in his preschool career. One's teaching would depend on what the mother already knew and what program she had been carrying on. The nurse's reaction to the general appearance of the child and his immediate environment would help a great deal in her teaching program.

She might start on the subject of diet and discuss a well rounded diet for a child of this age. One might also stress letting the child feed himself but with some help from the mother. If bladder and bowel control have not been established at all times, one could help by planning a program to overcome bad habits.

Prevention of diseases should be discussed and immunization for smallpox and diphtheria should be explained and urged if it has been omitted to date.

At the age of three the child should be exposed often and repeatedly to nursery rhymes and plenty of time spent over them as this may help to stimulate the child's imagination. Educational toys should also be encouraged. He should be allowed to play with children in the neighborhood and learn to share things.

A weight and height chart may be left with mother for comparison as the child grows and develops.

Dental information is always a welcome subject and at this time it may be explained that he should have his full set of baby teeth.

His clothing should be carefully observed and criticized if necessary, depending on the weather, the materials, and the fit of the garments. Freedom for growth and development should be the first aim.

He may suck his thumb, either when he naps or during the day. This habit requires patience and persistent effort to overcome. If the habit is replaced by a new and good one there are two things gained.

*Quotation "My Friend's Book" by Anatole France.

Fresh air, sunshine, exercise,—routine living conditions should always be discussed. The importance of health supervision and routine examinations should be explained as they prevent future disturbances and take care of any corrections in their infancy.

At this time the family may be anticipating another child in the family. The mother should be advised to prepare the preschool child for this event.

The child's room and bed are important. His room should be clean and have sunshine part of the day. The temperature should be uniform and the humidity right, as many colds are contracted in poorly ventilated rooms. He should have his own bed if possible with a firm hair mattress, and a very flat pillow, if any. Most mothers are too solicitous of their children and have them sleeping on soft pillows in a very warm room.

In these modern days one would think every mother would be intelligent about her children, with the aid of public health centers, public health pamphlets, and public health workers; but it is surprising to find the vast number of mothers who are bringing their children up the way they were brought up or taking the neighbor's advice when they are confused. Much can be accomplished on one visit but it would be ideal to make a second visit to see the fruits of one's labors!

HONOR ROLL

Agencies Holding 100 Per cent Nurse Membership in the N.O.P.H.N.

CALIFORNIA

*Visiting Nurse Association, San Francisco.
**Santa Barbara County Health Department, Santa Barbara

CONNECTICUT

***Public Health Nurse Association, Darien
**Visiting Nurse Association, Waterbury

ILLINOIS

*Metropolitan Life Insurance Nursing Service, Alton
*Cheerful Home Association, Quincy

INDIANA

**Public Health Nursing Association, Terre Haute

KENTUCKY

***Public Health Nursing Association, Lexington

MAINE

*Lewiston Bleachery and Dye Works, Lewiston
***District Nursing Association, Portland
**South Franklin County Nursing Service, Wilton

MARYLAND

*Montgomery County Health Department, Rockville

MASSACHUSETTS

***Newton District Nursing Association, Newtonville

MICHIGAN

***Visiting Nurse Association, Detroit
***Visiting Nurse Association, Saginaw

MISSOURI

***Visiting Nurse Association, Kansas City
*Municipal Visiting Nurses, St. Louis

NEW JERSEY

*Metropolitan Life Insurance Nursing Service, Camden
***Montclair Bureau of Public Health Nursing, Montclair
**Visiting Nurse Association of the Oranges and Maplewood, Orange
**Perth Amboy Chapter, American Red Cross, Perth Amboy
***District Nursing Association, Westfield

NEW YORK

***Albany Guild for Public Health Nursing, Albany
***Neighborhood House, Tarrytown

OREGON

*Clackamas County Health Unit, Oregon City
**Oregon Tuberculosis Association, Portland

PENNSYLVANIA

*Visiting Nurse Association, Coatesville

RHODE ISLAND

**Barrington Visiting Nurse Association, Barrington
**Richmond Visiting Nurse Association, Carolina
*Central Falls Health Department, Central Falls
*Universal Winding Company, Cranston
**John Hancock Insurance Company, Newport
*Metropolitan Life Insurance Company, Newport
*Burrillville District Nursing Association, Pascoag
*Portsmouth Branch, American Red Cross, Portsmouth
**Johnston Visiting Nurse Association, Providence
*Sayles Finishing Company, Saylesville
*North Kingston Visiting Nurse Association, Wickford
***Woonsocket Public Health Nursing Association, Woonsocket

VERMONT

***Brattleboro Mutual Aid Association, Brattleboro

WASHINGTON

*Visiting Nurse Service, Seattle

WEST VIRGINIA

*Hancock County Health Department
*Clay County Health Council, Clay

***100 per cent for three years
**100 per cent for two years
*100 per cent for one year

SCHOOL  HEALTH

RECORDS AND PUBLICITY*

I. GENERAL FACTORS TO CONSIDER IN CHOOSING AND USING RECORD FORMS

A. *Information on the records*

1. The information which is placed on records should be subject to these questions:
   - *a.* Is it meaningful both to the recorder and to others having access to the record?
   - *b.* Is it of significance to those who are responsible for the health of children, *i. e.*, to the nurse, the doctor, the dentist, the teacher, the parent, and the child?
   - *c.* Does it offer a basis for comparison so that the results of the follow-up program may be measured over a period of several years?
   - *d.* Is it convincing proof of the need for the maintenance and the promotion of the school health program?
   - *e.* How does it compare with that which is included in the school health appraisal form?

B. *Physical aspects of the records*

1. Records should be concise and brief so that they require the ***minimum*** of work on the part of the recorder with the ***maximum*** of information.
2. Symbols should be used when possible. The key to the symbols should be readily accessible to the observer and should be brief, accurate, and explanatory. The use of abbreviations should be avoided unless explained by symbols or unless their meaning is self-evident. Information should always be recorded in the space allotted to it.
3. The size, shape, and material of the records depends largely upon the local regulations, for very often they must conform in these respects to the other records used in the system.
4. The form should be organized so that related items are placed in juxtaposition, preferably in a vertical column, so that the eye can catch significant facts with a downward glance. Both sides of the record may be used, but if so, the items should be arranged so that the turning of the record is minimized. For example, the findings of the physician may be recorded on one side of the health record while the findings of the nurse's inspections and the dentist's examination may be recorded on the other side. The name of the child should be on both sides of the record.
5. Records should always provide spaces for dates and for the name or initials of the person making the record. It should also include some mark of identification as to school, city, and kind of record.
6. Records from which figures for compilations are taken and the forms upon which the compilations are made should be uniform in arrangement in order to conserve the time of the recorder. They should be so easily interpreted that a clerk may make the compilation.
7. Records upon which totals are compiled should provide space for totals and the recording in these spaces should stand out so that the eye can quickly see the total. This is very nicely done by the use of different colors, underlining, or setting off the figures by double lines.

C. *Filing*

1. Records should be filed in a systematic way and in a convenient place so that they are easily accessible to the person or persons using them.

D. *Catalogue of records*

1. Each nurse should have readily accessible a manual of procedures in which is included a catalogue of all the records for which she is responsible together with directions for using them. This facilitates procedures and is conducive to continuity and efficiency of program in spite of changes in nursing personnel.

II. KINDS AND USES OF RECORDS

A. *Attendance records*

1. Should be kept daily by the teacher.
2. Should be accessible to the nurse.
3. Should indicate absentees and the date of their absence.
4. Should indicate the reason for the absence as known by the teacher.

*This is the sixth topic in the study program for school nurses.

5. Should include the reason for absence after it has been obtained by the nurse.
6. Should be summarized at regular intervals, monthly or six-week periods, and annually.
7. Should be used:
   a. As basis for morbidity records of communicable diseases, including colds.
   b. As a basis for comparisons of attendance of one year with another; of school with school; of room with room.
   c. As evidence for the need of certain procedures for the improvement of individual health status and behavior and of environmental health conditions.

B. *Individual physical health records*

1. Should constitute one phase of the cumulative record of the child, which should include information regarding the psychological, emotional, and social status of the child. They should be kept throughout the child's school attendance, transferred with the other cumulative records when schools are changed.
2. Should include a history of communicable diseases, serious illnesses, immunizations, semi-annual record of growth in height and weight, findings of physician, dentist, and nurse, follow-up and corrections of defects.
3. Should be accessible to the teacher so that she can base her health instruction upon individual pupil needs. All recording upon this record, however, should be the nurse's responsibility to do or to supervise.
4. Should show that every item listed upon them has been given consideration by having the appropriate symbol written opposite it under the appropriate grade and date.
5. Should not have irrelevant information which might have only a temporary value. (This may be written lightly in pencil or may be written upon a case record card which may be used temporarily while intensive case work is being done.)
6. Should indicate plainly the following information in a code:
   a. No defect noticed.
   b. Defect noticed but no follow-up indicated.
   c. Slight defect noticed which needs to be watched by teacher, nurse, and school doctor but which does not need to be reported to parent.
   d. Defect needs attention.
   e. Defect corrected.
7. Give the information upon which follow-up is based.

C. *Summary of individual physical health records*

1. Should follow in plan the individual physical health record, so that the clerk can make the statistical compilations.
2. Should include in addition to the items listed, a record of the number of individuals for whom follow-up was indicated and the number for whom no follow-up was necessary.
3. Should be compiled according to schools, age, sex, and other factors, such as economic, in addition to the general summary. This seems detailed but is of value as a source for whatever information may be demanded.
4. Should be kept, so that over a period of years they may be used as a basis for comparisons which indicate health trends, need for change of program, and results of the program.

D. *Daily, monthly, and annual records of the nurse's work*

1. Should indicate briefly and accurately the nurse's activities and may include the following items:
   a. Readmissions
   b. Exclusions
   c. Cases of contagion
   d. Cultures taken
   e. Inspections of pupils
   f. First aid
   g. Advice and care
   h. Conferences with teachers, and parents at school, by phone
   i. Sanitary inspections
   j. Corrections
   k. Talks
   l. Meetings attended
   m. Time spent in school
   n. Time spent in home calls or other business relating to the school health program away from school
2. Serve as a reference for the nurse in case questions arise regarding the handling of individual cases; aids in planning distribution of her work so that it will be more effective; indicates work which has not been done which she would like to do.
3. Give the nurse a perspective of her work which she cannot possibly have without these objective evidences.
4. Should contain both statistical information and narrative accounts which lend human interest to the figures.

E. *Records or reports of a more or less temporary value*

1. Records or reports of this kind, though temporary, should have a definite form which is easily interpreted by the person to whom it is given and convenient for the person who does the recording.

2. Records or reports of this type are:
   a. Those which are given to the teacher by the nurse which indicate both the defects to be watched and the defects which need attention of the children in her classroom. This should be of shape and size which can conveniently be kept with the attendance record.
   b. Weight and height records should be given by the nurse to the teacher and should also be of a shape and size which can be placed with the attendance record.
   c. Records of health habits which need to be changed or improved should be kept by the teacher and should be of the shape and size of the attendance record so that they can be kept with it.

   Note: Information on the records named under *a, b, c,* and the attendance record should be used as a basis of individual and group health instruction.
   d. Reports or notifications which the nurse sends to parents should be kept in duplicate, so that the copy may be used as reference should the occasion arise. These should be on forms which contain the name of the school, which have a place for the date, the salutation, signature of the sender, and the information. There is an advantage in having these informal so far as the content is concerned.
   e. Individual reports of growth in height and weight over a several weeks' or months' period may be sent to parents of children who are too young to give the information verbally.
   f. Reports of sanitary conditions should be made out on forms containing items to be noted. These should be made out by the nurse, the custodian, the principal, for it is their joint interest and responsibility.*

III. PUBLICITY

1. Publicity is always an important consideration in the school health program. It should be planned as an integral part of it.
2. The points of contact should be every force in the community including health agencies, doctors, dentists, nurses, social agencies, community organizations, as well as those which are directly connected with the school. No group should be thought unimportant to contact.
3. The mediums of publicity are the newspapers, movies, radio, posters and literature, health talks, personal contacts, and conferences.
4. Publicity should be given out in small quantities repeated at more or less frequent intervals. The interest tolerance of the public cannot be sustained over a very long period at a time.
5. While a few people may initiate ideas for publicity, the more people involved in setting these ideas before the public the more far-reaching are the results of such publicity.
6. Good publicity is based on actual information which has a direct local application or significance. Careful selections from accurate records kept by the nurse together with her daily contacts serve as the bases for the best publicity which can be given in any given community.**

LESSON ASSIGNMENT

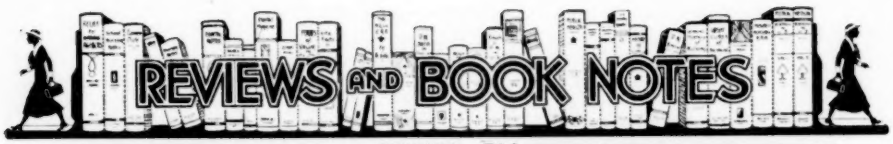
1. Using your records for a year make a graphic representation for two of the following:
   a. Morbidity of any three of these—diphtheria, smallpox, scarlet fever, measles, chickenpox, impetigo, scabies, whooping cough.
   b. Percentage of children in your school, or schools, who have defects needing attention Compare this item so far as children in the primary and intermediate grades are concerned with that of children in the upper grades.
   c. Percentage of children who failed to gain or who lost weight over a six months' period, using two six months' periods—this year's with a comparable period in 1930.
   d. Morbidity of several communicable diseases showing their incidence in different parts of the city, the county, or for different schools, depending upon the situation in which you are working.
2. Select some information from your records and write a convincing article to a board of education made up of hard-headed business men, showing them why the school health program should be maintained.

BIBLIOGRAPHY

Appraisal Form for City Health Work. American Public Health Association, pp. 63-73. $1.00.
Appraisal Form for Rural Health Work. American Public Health Association, pp. 45-53. $1.00.
The School Health Program. White House Conference on Child Health and Protection. D. Appleton Century Company, New York. $2.75.
School Nursing. Mary Ella Chayer. G. P. Putnam's Sons, New York. $2.50.

*Sample N.O.P.H.N. School Nursing Records can be obtained from Mead and Wheeler Co., 610 S. Michigan Avenue, Chicago, Ill.

**The N.O.P.H.N. is always glad to offer help in developing publicity.



EDITED BY
DOROTHY J. CARTER

WINDOWS ON HENRY STREET

By Lillian D. Wald. Little, Brown & Company, Boston, Mass. 1934. $3.00.

"Windows on Henry Street"! What public health nurse brought up on "The House on Henry Street" can fail to thrill at the thought of another book from Miss Wald. In all the tiresome "required reading" of student days "The House on Henry Street" was a veritable oasis, and now we have "Windows on Henry Street." Windows on the world might have been an equally appropriate title, for Miss Wald writes of many nationwide, worldwide movements: Child labor, peace, prohibition, Russia, drama, the arts—are they not just outside the windows of 265 Henry Street, if not on its very doorstep?

Public health nurses will naturally read the chapters on "Nursing and Health" with intense interest—in hundreds of cases, personal interest. Many, many "old Henry Streeters" remember the influenza epidemic, many understand perfectly what Miss Wald means when she writes: "It is important for nurses, and for those who have the training of nurses in charge, to comprehend how factual must be the methods used" . . . in teaching nurses to teach health. Many of Miss Wald's illustrations will help board members to understand our staff problems.

Be sure to read the chapters: Prohibition and the Four Million, The Lean Years, A Look Back and a Look Ahead. In fact, read all of this book, which pictures so vividly the social currents of our time and deals so sympathetically with the problems with which we are familiar.

Former Governor Alfred E. Smith writes of Miss Wald: "She started as a nurse and developed into a statesman of society." True, but she is still the nurse—observing, demonstrating, recording and giving her best thought to seeing that the patient receives adequate care. Nurses everywhere are proud that she has added "Windows on Henry Street" to the interpretive social history of our day. D. D.

SURVEY OF PUBLIC HEALTH NURSING

By the National Organization for Public Health Nursing. The Commonwealth Fund, New York. Price $2.00

Much has been written on public health nursing but never before has the subject been covered so completely as in the present work. As stated in the opening chapter, public health nursing covers a wide range of activities conducted under many settings, and there is an urgent need to take account of stock in order that there may be an accurate picture of the present stage of development, and an opportunity of utilizing the knowledge and experience gained in the past as a background and guide for the plans and methods of the future.

The survey comprises a critical study of the generally recognized standards, criteria, and goals of public health nursing, including a frank and impartial analysis of the results which have been obtained and the lessons to be learned from them.

The study shows that practically all public health nursing is administered by three major types of agencies, namely, public health nursing associations, departments of health, and boards of education. The findings in regard to the methods of administration and practice and the results accomplished reveal clearly what in the opinion of the Committee are desirable trends in public health nursing service today. The fact that 57 agencies in 28 communities gave freely of their information and experience with full knowledge that a critical analysis was involved is convincing evidence of their desire for the enlightenment which they felt that such a study would yield.

The book is unique in presenting the conclusions and recommendations in advance of the detailed subject matter. They are based upon the actual facts revealed by the study rather than upon opinions and impressions. They are logical, consistent, and contain sound philosophy and common sense. The discussion of the qualifications for public health nursing is particularly timely and both the strength and weaknesses of the present situation as regards the education of public health nurses are clearly set forth. One is pleased to find among the conclusions that public health nursing cannot be conducted as an isolated activity and that it cannot stand alone. Also, that any nursing service must have medical advice either from within or from without the agency and that the nurse must have medical authority for any procedures involving treatment.

Throughout the volume there is no tendency to withhold frank recognition of the defects of our administrative organization such as the multiplicity of agencies, the lack of adequate training facilities, the need of strong lay support, the development of a comprehensive community program, the need for adequate supervision, and the like. In this and other material the Committee has made clear, concise, and definite recommendations which, coming from a nursing organization, should be particularly effective.

WARREN F. DRAPER. M.D.

CONTAGIOUS DISEASES—WHAT THEY ARE AND HOW TO DEAL WITH THEM

By W. W. Bauer, M.D. Alfred A. Knopf, New York. 1934. Price $2.00.

Realizing that the intelligent mother in this day and age wants to know something about the causes and care of contagious diseases, Dr. Bauer has prepared this book, not, as he says, as a substitute for the physician but as a supplement. He discusses in clear and concise language the various factors involved in contagion, including quarantine and the technique of home nursing care. In spite of his carefully worked out descriptions of nursing care one wonders whether even an intelligent mother can grasp enough to put it into actual practice without a demonstration. Dr. Bauer does suggest that those "unfamiliar with bathing a patient in bed will find it worth while to employ the local visiting nurse, if one is available, or any trained nurse."

He constantly emphasizes medical supervision in his discussion and also warns his readers that the progress of science is continually revealing new facts and modifying methods. The book is a definite contribution to health literature. D. J. C.

RECENT PUBLICATIONS ON CHILD CARE

The Century Childhood Library. Edited by John E. Anderson, M.D. In three volumes. D. Appleton-Century Co., New York. $2.50 each.

Happy Childhood. By John E. Anderson
Busy Childhood. By Josephine C. Foster
Healthy Childhood. By Harold C. Stuart.

Infants and Children—Their Feeding and Growth. Frederic H. Bartlett, M.D. Farrar and Rinehart, New York. $1.50.

Our Children—A Handbook for Parents. Edited by Dorothy Canfield Fisher and Sidonie Matsner Gruenberg for the Child Study Association of America. Viking Press, New York. $2.75.

A selected list of references on "The Care of the Child from One to Six" has been prepared by Dr. Clara E. Hayes for the American Child Health Association, 50 West 50th Street, New York. Single copies free.

CAMPS AND CAMPING

A new book just off the press! "Keeping Campers Fit" by Elena E. Williams, R.N. E. P. Dutton & Co., New York. Price $2.50. To be reviewed in a later number.

A bibliography on "Camps and Camping" is available from the Russell Sage Foundation, 130 East 22d Street, New York. Price 10 cents.

Summer Camps: A Guide for Parents, edited by Beulah Clark Van Wagenen, may be procured from Teachers College, Columbia University, New York, for 25 cents. It includes sections on Camping for Children, Creative Ideas in Children's Camps, Basic Considerations for the Camp, and a bibliography.

The March number of *Mother and Child* (London) contains the following articles: The Influence of the Home on the Nutrition of the Child; Good Posture in the Little Child; Communal Mothercraft.

FROM THE CHILDREN'S BUREAU

Child Health Recovery Program Flier. A schedule of hygiene and care for an undernourished child two to sixteen years of age. Free from the Children's Bureau, Washington, D. C.

Good Posture in the Little Child. Order from the Superintendent of Documents, Washington, D. C. 5 cents.

Guiding the Adolescent. D. A. Thom, M.D. Order from the Superintendent of Documents. 10 cents.

Child Labor—Facts and Figures. Order from the Superintendent of Documents, Washington, D. C. 10 cents.

In spite of inadequate diets of both mothers and children rickets is rarely found among the children of Puerto Rico according to the study conducted by Dr. Martha M. Eliot for the U. S. Children's Bureau. While many of the 600 children examined seemed to be poorly nourished, the X-ray pictures showed practically no evidence of a rachitic condition. The year-round exposure to sunlight has demonstrated its effect. *The Effect of Tropical Sunlight on the Development of Bones of Children in Puerto Rico.* Ten cents from the Superintendent of Documents, Washington, D. C.

A set of pamphlets dealing with eye care of small children will be sent by the National Society for the Prevention of Blindness, 50 West 50th Street, New York, upon receipt of twenty-five cents. The list includes:

Testing the Vision of Preschool Children
Vision Testing and Eye Inspection—An Essential Part of the Preschool Health Examination
The Eyes in Childhood
Eye Accidents in Child Play
Eye Injuries and Sympathetic Ophthalmia
Facts and Fallacies Concerning Squint
Nutrition in Relation to the Eyes
Care of Child's Eyes in Case of Measles
Babies' Eyes in the Summer

Nursery Schools: Their Development and Current Practices in the United States may be obtained from the U. S. Office of Education, Washington, D. C. 15 cents.

An outline for a study course on the preschool child has been appearing monthly in *Parent's Magazine*, 114 East 32d Street, N. Y., during the winter 1933-34.

Nearly one-half of the appropriations of the Commonwealth Fund for 1933 went to the broad field of health, according to their *Annual Report for 1933*. Of particular interest in the report is the brief description of "Fargo Five Years After," showing that the work on a demonstration basis instigated by the Fund has been proceeding without interruption since the withdrawal of Fund support five years ago. The Commonwealth Fund, 41 East 57th Street, New York City.

FROM CURRENT PERIODICALS

Before baby is two is the title of a series of articles on habit training of the infant and young child appearing monthly in Hygeia commencing last November. By Katherine Brownell Oettinger.

The contribution of the nursery school to the health needs of the preschool child. C. A. Wilson, M.D. Medical and Professional Woman's Journal, Cincinnati, 41:55-59, February, 1934.

How health affects personality. By Samuel W. Hartwell, M.D. What effects health and contacts with physicians may have on children. Child Welfare for February. Also in the same number, *Amusing young patients.* By Louise C. Hastings.

Preschool examinations by the family doctor. Editorial. Journal of American Medical Association, September 16, 1933.

Making spinach edible. By W. R. Dunton, Jr., M.D. Hospital Social Service for September, 1933.

Beginning with the April number the Survey Graphic is planning to emphasize throughout the rest of the year the many problems relating to medical care and public health. In April are articles by Daisy L. W. Worcester, Dr. C.-E. A. Winslow, Edgar Sydenstricker, and Michael M. Davis.

The University of Hawaii in Honolulu is offering a course in Public Health Nursing for the academic year 1934-1935. This course was organized several years ago at the request of local groups, through the joint interest and participation of the University of Hawaii, the Territorial Board of Health and Palama Settlement. The theoretical courses are given in the University and field practice is arranged with local nursing groups in Honolulu and in some of the rural districts in the Territory. The course is not offered every year but only when there is a sufficient number of applicants to warrant it. Miss Amy MacOwan, Director of the Palama Settlement Nursing Service, serves as Director of the course.

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The American Public Health Association will hold its sixty-third annual meeting in Pasadena, California, September 3-6, 1934.

✣

The Medical Society of New Jersey is working out a new plan to extend the services of private physicians to all the people of the state (including the indigent), preserving the intimate relationships between physician and patient and the free choice of physician by the patient. The first project on which the Society is working is the establishment of a "Public Health Hour" for preventive service at low cost. Diphtheria immunization of the preschool group is first chosen since it has wide popular appeal, is easily understood and explained, and is needed. The Public Health Committee of the State Medical Society has been studying the community health needs for several years, and has arranged that the State Department of Health supply physicians with toxoid free. The plan is to ask local physicians to offer a "public health hour" at stated times, outside his regular office hours, at which immunizations will be given. The "public health hour" will provide about three thousand additional health centers in the State and immunization will be done for a dollar per injection and will be given free to those who in the physicians' estimate are worthy. As rapidly as the lists of physicians are ready and their "hours" designated, social and health workers are informed and asked to coöperate in the plan by referring children in need of immunization. Other projects await the response to this first effort.

✣

The National Tuberculosis Association and Joint Vocational Service have recently entered into an arrangement, whereby J.V.S. will handle graduate nurse positions in tuberculosis sanatoria. This is based upon the public health implication in institutional tuberculosis work and the need of public health nurses for this type of experience. This action was taken after consulting the National League of Nursing Education.

✣

A modern tuberculosis sanatorium for the Indians of Minnesota is to be constructed in the near future as a result of a ten-year campaign in the state for this much needed service. The sanatorium has been made possible by a Federal appropriation of $250,000 and a gift of forty acres of land by the State of Minnesota.

✣

The Ninth Conference of the International Union Against Tuberculosis will meet in Warsaw, Poland, on September 4, 5, and 6, 1934, under the chairmanship of Prof. Pieztrzynski. Reports will be made on three subjects as follows: "Biological variations of the tubercle virus" by Prof. Karwacki of Poland; "Tuberculosis of the bones and joints" by Prof. Putti of Italy; and "The use and organization of tubercu-

losis dispensaries" by Prof. Leon Bernard of France. The representatives of the United States who will take part in the discussions are Dr. Esmond R. Long of the Phipps Institute, Philadelphia; Dr. Clarence L. Hyde of the Springfield Lake Sanatorium, East Akron, Ohio; and Dr. B. S. Pollak of the Hudson County Tuberculosis Sanatorium, Secaucus, New Jersey. There will also be an afternoon lecture by John A. Kingsbury of the Milbank Memorial Fund, New York, on "Methods in further control of tuberculosis."

A special party is being arranged from the United States and for those who can leave in advance a trip to Russia is scheduled that will permit delegates to arrive in Warsaw in time for the meeting. Further information may be obtained by addressing the National Tuberculosis Association, 50 West 50th Street, New York.

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The Annual Meeting of the American Home Economics Association will be held in New York City, June 25-30, at the Hotel Pennsylvania.

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Miss Alma C. Haupt and Miss Evelyn K. Davis will represent the National Organization for Public Health Nursing at the National Conference of Social Work in Kansas City, Mo., May 20-26, and will be available for appointments at the N.O.P.H.N. booth.

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At a recent meeting of the Executive Committee of the Trustees of Western Reserve University, it was voted that with the admission of the September, 1934, class, the School of Nursing shall become one of the graduate professional schools of the University. This means that hereafter applicants who are admitted as students to the course in nursing must submit credentials showing the completion of a course leading to the Bachelor's Degree in Arts, Science, or Philosophy in a college of approved standing. The faculty of the School is revising the curriculum which, together with all activities, will conform to those of a graduate school.

✣

The Michigan Board of Registration of Nurses will hold an examination June 7-8 for graduate nurses, June 7 for trained attendants, at the Olds Hotel, Lansing. All applications with fees must be on file in the office of the Board of Registration of Nurses, 200 Hollister Building, Lansing, not later than May 23. Mrs. Ellen L. Stahlnecker, R.N., Secretary.

ADDITIONAL SUMMER COURSES

University of Alabama, University, Ala. First term June 4-July 13. Offers a course in the Social Aspects of Public Health Nursing and other courses in nursing education. **Miss Katherine Dick, Instructor.** For further information write to **Dean of Summer Session.**

University of Kentucky, Lexington, Ky. Summer session beginning June 11. Courses in Community Health Education. Miss Elma Rood, Instructor.

For further information write to Dr. Jesse Adams, Dean of Summer School.

Trenton State Teachers College, Trenton, N. J. Will offer summer session courses in Health Supervision, Health and Safety Education, and School Nursing. **Lula P. Dilworth, Instructor.**

For further information write to Miss Lula P. Dilworth, Department of Public Instruction, Trenton, N. J.

The following universities will offer courses for the training of teachers and supervisors of sight-saving classes this summer. They are as follows:

State Teachers College, Buffalo, N. Y.
University of Chicago, Chicago, Ill.
University of Cincinnati, Cincinnati, O.
Teachers College, Columbia University, New York, N. Y.

For further information write to the National Society for the Prevention of Blindness, 50 West 50th Street, New York.